University of Alberta

Governing Criminal Insanity in the Community:

The New Spatial and Ethical Territories of the "Not Criminally Responsible"

by

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Abstract

Individuals deemed criminally insane personify uncertainty, ambiguity and danger. Historically, this matter was resolved by confining the accused in either a prison or a psychiatric hospital. More recently, most individuals found 'Not Criminally Responsible' are discharged from forensic psychiatric inpatient settings to the community and come under the regulation of a forensic psychiatric outpatient clinic. This thesis argues that this shift in the care and control of criminal insanity exemplifies a shift in strategies of regulation from liberal to advanced liberal modes of governance.

To examine this thesis, qualitative data were collected through the observation of interactions between individuals found Not Criminally Responsible who were discharged to the community and psychiatric professionals employed at a forensic outpatient clinic. The findings reveal that the governance of criminal insanity does not always fit unproblematically with the theoretical propositions of advanced liberalism. Within this setting, the regulation of criminal insanity is an amalgam of liberal and advanced liberal strategies and techniques. The analysis explores several themes of governance, including surveillance practices, risk assessment and management, resistance tactics and the ethical formation of the self.

A common focus of all these themes is the concept of responsibility. Individuals found Not Criminally Responsible must demonstrate and be seen to be responsible for a vast array of activities including the regulation of their own

behaviour, thoughts and emotions. This process of 'responsibilisation' is necessary in order for these individuals to progress through and eventually be discharged from the psychiatric-legal system that regulates their day-to-day lives.

Ultimately, the regulation of these individuals attempts to strike a balance between, on one side, providing treatment for a mentally ill individual and security for the community from a potentially dangerous criminal, and, on the other, the individual's struggle for personal rights, independence, and freedom.

Dedication

To those who participated and to those who were patient.

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Chapter One - Introduction

Few members of our society garner more misunderstanding and engender more fear than those individuals who, after having committed a crime, are found not guilty for reasons of insanity. Hollywood and the media have certainly provided us with vivid portrayals of the deranged madman on a crime spree. Academia has done little to counter these images, concerning itself mainly with the factors associated with, or the probability of, relapse and/or re-offence of these individuals. Despite the intrigue with which we view these persons, the motives for raising the mental disorder defence are often misunderstood, and even less is known of these individual's actual experiences within the mental health care and legal systems.

No single depiction adequately represents the criminally insane or the acts they commit. These individuals come from all walks of life with a wide variety of life histories. Some have had encounters with mental health and criminal justice agencies, but many have not. While some incidents deemed criminally insane involve extremely serious events such as arson or murder, most are relatively familiar crimes such as uttering threats or minor assault. For example, typical scenarios include a young man assaulting a family member; a husband beating his wife; a mother striking her child; or an individual causing a disturbance in a public place. Most of these events do not capture the attention of the local newspaper reporter, let alone the Hollywood screenwriter.

Likewise, the usual explanations for these crimes – e.g., anger, frustration, confusion – are as simple and straightforward as the incident itself. A small number of offences are less comprehensible and may include delusions or unprovoked attacks on family, friends or, on rare occasions, strangers. The only common feature that all individuals deemed criminally insane share is that they faced a criminal trial where they were exonerated of criminal responsibility for the incident because a mental disorder was thought to interfere with their ability to form criminal intent.

Individuals found criminally insane are often assumed to be extremely dangerous and pose an imminent threat which requires confinement and constant monitoring. Historically, these individuals faced a wide range of responses including banishment, segregation or hospitalisation. In Canada, both historically and currently, nearly all persons found 'Not Criminally Responsible on Account of Mental Disorder' (NCR)[1] will spend a period of time as inpatients in a forensic psychiatric facility. Such indefinite confinement in a psychiatric facility was the only response to criminal insanity until the last quarter of the 20th century. More recently, most persons, at some point in their tenure as NCR, will also find themselves discharged from an inpatient setting to live in the community. In these cases, the individual must abide by conditions set out by a legal Board of Review, which always includes the stipulation that they attend regular appointments at a forensic outpatient clinic. In this setting, they are assessed, monitored, regulated and treated by a team of psychiatric professionals.

This thesis argues that this shift in the care and management of the criminally insane, from the exclusively inpatient settings of the past to a combination of inpatient and outpatient settings, exemplifies a shift from 'liberal' to ‘advanced liberal’ forms of regulated conduct. It does so by drawing upon the findings of a research project that relates the current approaches to, and regulation of, criminal insanity in a community forensic psychiatric setting to these broader developments in contemporary forms of governance. Such data allow me to suggest that while some practices in this setting are congruent with the theoretical postulations of advanced liberalism, the current forms of regulation of criminal insanity are a complicated fusion of strategies and techniques. Thus, through an empirical foundation, this thesis provides a more nuanced understanding of contemporary modes of governance.

The practice of discharging psychiatric inpatients to community settings, commonly known as ‘deinstitutionalization’ or ‘decarceration’, first gained attention in the 1950’s and 1960’s (see Cohen 1985; Mechanic and Rochefort 1990; Scull 1984). This policy does not simply amount to the release of individuals from institutions to the community; it also represents a transformation in the strategies and practices of regulating such patients. As such, deinstitutionalization could more accurately be understood as a blurring of the boundaries between ‘inside’ and ‘outside’ the institution. In particular, community psychiatric regulation includes not only the practices of psychiatric professionals employed in outpatient clinics, but also other members of the community such as social service workers, family, employers, and significantly, the deinstitutionalized individual him or herself. This heterogeneous group provides a network of psychiatric care and regulation which focuses simultaneously on maintaining the individual in the community and providing safeguards against any potential harm that the individual may commit against him/herself or others.

In Canada, the majority of forensic psychiatric outpatient clinics were established in the 1960's and 1970's. The main forensic psychiatric outpatient clinic in Alberta, affiliated with Alberta Hospital Edmonton, was established in 1976. This clinic, known as Forensic Assessment and Community Services, is the primary facility in Alberta that provides the care and regulation of individuals found Not Criminally Responsible who are released to the community. When discharged from the inpatient facility, the majority of Albertan NCR individuals are required to reside in the Edmonton area and attend this clinic on a regular basis. Within this site, and through the psychiatric professionals that are in its employ, a delicate balance is brokered. On one side of the balance is concern for the care of a mentally ill individual, regulation of a potentially dangerous criminal and protection of the community at large. On the other side of the balance is the individual's struggle for rights, independence, freedom and self-determination. Possibly, in no other setting or with no other group is this delicate balance more acute than in the treatment and control of the criminally insane in a community forensic psychiatric clinic.

In the last quarter of the 20th century, the care and regulation of criminal insanity has gradually shifted to emphasize forensic psychiatric outpatient settings. In Alberta, over the last two decades, the ratio of NCR outpatients to inpatients has steadily increased (Gulayets 2001). Currently, there are approximately 30 individuals found NCR residing in the forensic inpatient facility at Alberta Hospital Edmonton and approximately 100 individuals found NCR supervised in the community by psychiatric staff at Forensic Assessment and Community Services. While the number of NCR inpatients has remained constant over the years, the number of NCR outpatients has steadily increased.

Research Thesis

With the growing importance of community settings in the treatment and regulation of individuals found Not Criminally Responsible, it is paramount that we gain a better understanding of the mechanisms that constitute the governance of criminal insanity in these sites. I am using the term 'governance' in the Foucauldian sense, that is, to govern is to *attempt* to regulate, control, manage, or direct an outcome (Foucault 1991). Of interest are governmental mechanisms that include both *governmental rationalities* (i.e., systems of thinking about the practice of government, for example who can govern, what constitutes governing, and who is governed) and *governmental techniques* (i.e., the actual tactics through which authorities attempt to shape or influence the conduct, actions, decisions, etc. of others in order to achieve a desired outcome).[2]

This thesis analyses the rationalities and techniques by which psychiatric professionals attempt to govern the conduct of those found NCR, and also how individuals found NCR self-regulate or govern themselves. The aim of both the mechanisms of regulation by psychiatric professionals and the forms of self-regulation by individuals found NCR is to create – or attempt to create – a 'responsibilised' citizen. This process of 'responsibilization' occurs when individual actions and choices are governed and/or self-governed through rationalities and techniques that are consistent with the goals of political, social and economic authorities. I demonstrate that the ultimate goal of community forensic psychiatric professionals is to construct (or reconstruct) autonomy and self-responsibility in individuals found NCR. Likewise, individuals found NCR are encouraged to create a self that is responsible to itself and others. As demonstrated by this process of responsibilization, the direct and coercive mechanisms of governance utilised by 'liberal' forms of rule are increasingly augmented or replaced with indirect mechanisms characterised by 'advanced liberal' forms of governance. Thus, this thesis analyses the rationalities and techniques of governance within a forensic psychiatric outpatient clinic as an exemplar of advanced liberalism.

Governmental scholars describe a shift, beginning near the end of the 20th century, from liberal to advanced liberal governmental rationalities and techniques (for example see Barry et al. 1996 and Rose 1999a). As discussed in detail in Chapter Three below, liberalism is a form of governance that operates through social systems that promote the effective management and well being of citizens, as exemplified by the welfare state. Social settings (e.g., hospitals, schools, courts, clinics, etc.) are organized around forms of knowledge or expertise which serve as the basis upon which governance operates. This network of social settings and individuals is the object of liberal forms of governance.

Advanced liberalism, on the other hand, emphasizes rationalities and techniques that encourage economic and administratively efficient modes of governance. Rather than a single, interlocking social network, modes of regulation are individualized or fragmented. For example, advanced liberal mechanisms encourage individuals to become active in securing their own goals and well being rather than depending on the state. Translated to the discipline of psychiatry, advanced liberal forms of governance seek to align clinical expertise with administratively efficient practices. Thus, the use of inpatient facilities and the reliance on clinical expertise is augmented with practices that facilitate or encourage patients to self-govern and care for themselves.

The central finding of this thesis is that governing criminal insanity within this forensic psychiatric outpatient clinic is not a straightforward reflection or manifestation of advanced liberalism. As demonstrated in detail in the chapters below, the modes of regulation within this setting do not always correspond unproblematically with the theoretical descriptions of advanced liberalism. Rather, from a theoretical perspective, governance of criminal insanity within this setting is lurching, messy, and liminal, incorporating an amalgam of liberal and advanced liberal modes of governance. Hence, by drawing upon an empirical analysis of governance in practice, this thesis contributes to the governmentality literature and reveals that advanced liberal modes of governance are more complex, at least in relation to criminal insanity, than is often suggested in the literature.

Methodologically, I employ a case study approach which examines the forensic psychiatric outpatient clinic as a 'case' of governance. Research participants include individuals found Not Criminally Responsible and forensic psychiatric professionals (e.g., psychiatrists, psychologists, social workers, nurses). Qualitative data were collected through the observation of interactions between participants in a variety of settings, including individual appointments between a staff member and a patient, staff case conferences, and meetings and conferences attended by both staff and a patient.

The objective of this thesis is to provide a *diagnosis* of the current rationalities and practices that govern criminal insanity in the community. Such an approach has benefits that are both broad and specific. For example, it contributes to a better understanding of how advanced liberal conditions and practices are incorporated and operate within institutions in the form of knowledge, interpersonal practices and self-governance. In addition, this research provides a specific understanding of the situations experienced by individuals found Not Criminally Responsible, as well as an understanding of how psychiatric professionals attempt to treat and manage these individuals in a community setting.

While there is abundant research and literature on the jurisprudence of criminal insanity (e.g., Perlin 1994), the meaning of criminal insanity (e.g., Fingarette 1972; Robinson 1996), legal aspects of the insanity defence (e.g., Spring et al. 1997; Weisstub 1980), moral/ethical aspects of criminal insanity (e.g., Elliot 1996; Reznek 1997), and the psychiatric assessment and treatment of the criminally insane (e.g., Bluglass and Bowden 1990; Rosner 1994), there is little empirical research on the actual situations experienced by individuals found NCR (Arrigo 1996; Livingston et al. 2003; Menzies 2002) or the psychiatric professionals who deal with them in community settings.

My thesis emphasises not only the actual situations of individuals found Not Criminally Responsible, but examines the institutional role of psychiatry in the care and management of the criminally insane. It focuses on the experiences of the patients and staff, and explores the micropolitics of institutional discourses and practices that denote, support and contradict advanced liberal conditions. Foucault (1982:222) suggests that while an institution may consolidate micropolitical relations, these relations do not originate in institutions; rather, forms of knowledge and interpersonal practices reflect underlying relations. Therefore, the analysis of institutions should occur from the standpoint of power relations, not vice versa. In other words, the essence of power relations is found outside of institutions, even if they find expression within institutional contexts. Hence, governing criminal insanity reflects socio-political themes.

Chapter Outline

The above arguments and evidence are presented in two distinct parts. The first part, comprising Chapters Two through Four, provides a framework for the research project; the second part, Chapters Five through Eight, presents the empirical findings. Finally, Chapter Nine offers concluding remarks.

Specifically, Chapter Two presents a brief overview of the mental disorder defence and the legal dispositions (i.e., placement orders) imposed upon persons found criminally insane in Canada from the mid 18th century to the present. This historical narrative provides a context upon which contemporary forms of regulation can be compared.

The next chapter places these strategies and techniques into two broad theoretical approaches. The first involves a 'macro' perspective that focuses on the historical and socio-political forces that shape the concept of criminal insanity. The second, a 'micro' perspective, emphasizes the interpersonal, face-to-face interactions that occur within institutional settings and constitute the day-to-day governance of those found criminally insane. These two approaches guide this study and are represented, respectively, by the work of Michel Foucault and Erving Goffman. The first portion of this third chapter discusses the contributions of each of these scholars to the study of insanity, while the remainder of the chapter considers the mechanisms of liberal and advanced liberal modes of governance in the regulation of criminal insanity. This provides the theoretical framework for the research observations.

The fourth chapter argues that a case study method provides an effective approach to study forms of governance in a specific setting. Included in the chapter is discussion of the research setting and participants, and the data collection opportunities and procedures. It concludes with ethical considerations and a reflection of the research process.

With the historical, theoretical and methodological frameworks in place, the ensuing chapters analyse the research findings. The central theme here is the interplay between techniques of regulation carried out by psychiatric professionals that objectify the individual, and techniques of the self exercised by individuals striving to create ethical selves. The findings suggest that in order for individuals to proceed through and eventually be released from this psychiatric-legal system, they must be seen to be governable in the community, and one of the primary ways to establish this is to demonstrate responsibility. Thus, the combination of objectifying and subjectifying techniques results, ideally, in a responsibilised individual. Chapters Five through Eight analyse how this process occurs by focusing on several themes central to the governance of the criminally insane.

Specifically, Chapter Five, '*Surveillance*', examines how criminal insanity is made visible and knowable within the forensic psychiatric outpatient clinic. Institutional practices, such as the clinical appointment, are used to scrutinize and monitor potentially troublesome qualities of patients. In addition, individuals found Not Criminally Responsible must also demonstrate 'insight', or the ability to identify, examine and articulate their own thoughts, emotions, and behaviours in a manner consistent with psychiatric knowledge. Effectively, panoptic forms of surveillance are augmented with forms of regulation that require individuals to be responsible for monitoring themselves and communicating the findings to those in authority.

Surveillance techniques facilitate other forms of regulation. In particular, as individuals come under greater scrutiny, more factors become available to be assessed as 'risky' and thus require management. Chapter Six, '*Risk*', delineates the relationship between criminal insanity and the assessment and management of risk. It accentuates how criminal insanity is typically seen as synonymous with ambiguity and uncertainty and thus presents the potential for danger. Psychiatry has emerged as the predominant discourse involved in the prediction of the risks posed by the criminally insane. This chapter illustrates how psychiatric professionals assess risk through both clinical and actuarial techniques. In addition, the assessment and management of risk involves the participation of patients, who increasingly must be responsible for identifying and regulating their own risk factors.

Techniques of regulation, such as surveillance and risk management, provide opportunities for resistance. Chapter Seven, '*Resistance*', explores the interplay between strategies that attempt to govern the conduct of persons found Not Criminally Responsible and the strategies used by these individuals to try and counteract these forms of governance. Given the asymmetrical nature of power relations within this setting, I argue that everyday forms of resistance (e.g., feigned compliance, lying, not showing up for appointments, disagreeing, etc.) are significant tactics in strategic power relations. The chapter outlines how individuals resist power strategies and what specific tactics are resisted against. Here, once again, patients must demonstrate responsibly through a process I term 'responsibilised resistance', which is resistance with a demonstration of responsibility.

As highlighted in Chapters Five through Seven, responsibility can be demonstrated in various ways such as having insight, taking responsibility for identifying and managing risk, or even engaging in forms of resistance that, paradoxically, indicate responsibility. Each of these tasks is accomplished in a delicate and intricate interplay between individuals found NCR and psychiatric professionals. Chapter Eight focuses specifically on the domain of ethics, that is, the subjectifying techniques by which individuals constitute and experience themselves as subjects. Here, I direct specific attention to the techniques which individuals found NCR undertake in order to demonstrate a responsible self. The chapter explores 'etho-political' processes where psychiatric professionals encourage individuals to act responsibly and, likewise, where individuals found NCR demonstrate the ability to act responsibly.

Chapter Nine, the final chapter, provides concluding remarks to this thesis. It reviews the main findings and discusses the implications of this research project. In particular, contrary to common perceptions, this setting does not just incorporate coercive forms of regulation, but also requires and encourages individuals to exercise self-regulation. This situation establishes a complicated balance between security and freedom that is played out daily in the forensic psychiatric outpatient clinic.

Chapter Two – Historical and Legal Framework

For the last century and a half, individuals deemed criminally insane found themselves uniquely situated within powerful and often stigmatizing institutions – the legal, criminal justice and psychiatric systems. In Canada, in the mid 19th century, persons who committed a crime but were believed to possess a ‘disease of the mind’ were deemed criminally insane and confined within the Kingston Penitentiary, often for the rest of their lives. By the early 20th century, individuals found criminally insane were sent to insane asylums, where, behind a veneer of psychiatric treatment, they were also usually confined indefinitely. By the end of the 20th century, arguments arose that detaining the criminally insane, without regular review, or legal provisions for discharge, violated the human rights of these individuals. The result was a change to the laws concerning criminal insanity. Since 1992, these persons are no longer called criminally insane, but Not Criminally Responsible; they are no longer thought to suffer from a disease of the mind, but rather possess a mental disorder; and a legal Board of Review is to determine, on an annual basis, taking into account the rights of the person and the protection of society, if the individual should be detained in a psychiatric hospital, discharged to the community or discharged absolutely.

This chapter provides the historical and legal frameworks of the mental disorder defence and the possible dispositions, or placement orders, faced by individuals deemed criminally insane. The objective is to demonstrate that the approaches to criminal insanity reflect socio-political themes, which provide a context for the examination of transitions in modes of governance. It begins with a broad discussion of the fundamentals pertaining to the concept and determination of criminal insanity, with emphasis on English criminal law and procedures, as this legal system forms the basis of early Canadian criminal law. Following is a more specific history of criminal insanity in Canada from the end of the 19th century to the present. The chapter concludes with a detailed examination of the current mental disorder defence and dispositions. These legal regulations structure the legal rights, entitlements, and much of the day-to-day routines of individuals found Not Criminally Responsible.

Criminal Insanity in Historical and Socio-Political Context

It is commonly held that those who commit an act with purpose and intent should be held responsible for that act, and conversely, those whose acts are not committed with purpose or intent should not be held responsible for that act. This notion is an intuitive part of our moral outlook. More explicitly, it serves as the very basis of the Western legal system. However, the apparent simplicity of this commonly held belief becomes obfuscated when the mental state of the actor is an issue. Since antiquity, persons considered insane have often been relieved of responsibility for their actions. The reason for mitigating this basic principle of responsibility is the longstanding belief that a 'distorted' mental state at the time of the deed might provide an appropriate reason to exonerate responsibility for that deed (Appelbaum 1994; Fingarette 1972; Robinson 1996). Put simply, "none of the purposes of the criminal law would be served by punishing the insane (…) our collective conscience does not allow punishment where it cannot impose blame" (Robin 1997:224). These longstanding notions have served as the essence of insanity acquittals for centuries. And while the core principle, that a person who was insane at the time of the act should not be held responsible for that act, has not changed, there has been considerable change in the attitudes and responses toward persons considered insane.

Despite centuries of identifying insanity cases, the exact nature or cause of insanity has eluded legal, medical, philosophical and lay explanation (Fingarette 1972; Robinson 1996). Beginning in approximately the 16th century, as Foucault (1965) contends, the root of the concept of insanity was forged through a connection between insanity and the uniquely human faculty called reason. "The insanity plea expresses, in however awkward and circumscribed a way, the principle that one who has *lost his reason* may not be criminally condemned, that criminal law is a law for those who can be held responsible for what they do" (Fingarette 1972:7 emphasis added). This statement links reason and responsibility and holds that the essence of responsibility is intimately connected to reasoning faculties. It is the breakdown or absence of these faculties that signifies insanity and thus the potential for exculpation of responsibility.

To say that one has 'lost her reason' is an assessment of the rationality in one's conduct (e.g., an irrational mood, delusory beliefs, hallucinatory perceptions, flatness of emotional response, or perverse desires and tastes). Put the other way, irrational conduct is conduct "which is not in accordance with reason, in its relation to practical affairs" (Fingarette 1972:180). However, irrational behaviours are not simply socially disapproved behaviours, such as cruelty, recklessness, or incompetence. Socially disapproved behaviours are intelligible behaviours that fall outside of what is considered normal or appropriate in a given situation. Irrational conduct, on the other hand, is not another type of inappropriate or socially disapproved behaviour, but behaviour characterised by the absence of intelligible properties. It is conduct that cannot be fit to *any* point on a socially normative standard.

In short, in Western society, reason refers to a crowning faculty of human beings, and rationality refers to the behavioural manifestations of that faculty. Further, insanity refers to the character of the person who has 'lost his reason' and commits irrational acts. However, irrational and insane are not synonymous. One can commit an irrational act and not necessarily be considered insane, but the inverse is not true – insanity is always characterised by irrational acts. It is when 'irrational' is used to characterise not only the intellect but also the emotions, attitudes, desires and the person himself, that the person is considered insane (Fingarette 1972).

Determining Criminal Insanity

Once the link between reason and responsibility is forged, what remains is to identify cases in which certain behaviours or states imply rationality and thus responsibility for actions and, conversely, which behaviours or states imply insanity and thus exculpate responsibility.

At the most basic level, criminal responsibility, in Western jurisprudence, is determined by the presence of both *actus reus* and *mens rea*.[1] While there is considerable literature surrounding these concepts, for the present purposes, it suffices to say that in criminal law a person is deemed criminally responsible for an act when he or she committed the act (i.e., *actus reus* is present), and the act contained criminal intent (i.e., *mens rea* is present). Guilt cannot be assigned unless both of these elements are present. Hence, to say that a person is not criminally responsible for an act is to say that either he did not commit the act (i.e., *actus reus* is lacking), or if he did commit the act, it was not with criminal intent (i.e., *mens rea* is lacking). This relatively straightforward tenet of criminal law is complicated when an individual commits an illegal act but the mental state of the defendant is thought to compromise the criminal intent of the act. Criminal law maintains that it would be inappropriate to hold a person criminally responsible when that person's mental state at the time of the incident prevents the ability to form *mens rea*. This is the basis of the insanity defence.

For centuries, criminal responsibility was determined using lay determinants (Eigen 1995; Foucault 1978a; Robinson 1996). Until approximately the end of the 18th century, jurists considered "the planning, rationale, consequences, and overall organisation of the events culminating in the offence" (Robinson 1996:110). Therefore, to impose guilt, one simply had to find the perpetrator of the act and confirm that there was no valid excuse for the crime and that the individual was not in a state of furor (i.e., an acute occurrence of insanity) or dementia (i.e., a permanent state of insanity). Traditionally, *mens rea* was discovered in the act itself. For example, in establishing criminal insanity, the pre-19th century English court called witnesses to testify to the accused's state of mind. It was believed that furor or dementia revealed itself in such manifest ways that anyone could recognize it – specialized expertise was not necessary to authenticate madness (Eigen 1995). In the absence of a valid excuse or signs of insanity, the offender was found guilty and punished accordingly. However, with the confirmed presence of insanity, the perpetrator was relieved of criminal responsibility for the act.

In the early 19th century, English criminal law procedures regarding criminal insanity underwent subtle but significant changes (Eigen 1995; Wiener 1990). One significant change concerned the nature of the witnesses called to testify regarding the mental state of the defendant. In an attempt to seek an advantage in the courtroom via the supposedly objective claims of science, legal professionals increasingly called upon medical practitioners to testify. From this time forward, the courts and medical experts would enter a new, mutually beneficial relationship.

Medical practitioners came to hold more influence in the English courtroom based on their claim to expertise in the assessment, diagnosis, care, and control of the insane. This new found expertise derived from two sources: direct experience as medical practitioners in asylums and prisons, and in linking their practices, methods and forms of knowledge with rational scientific methods. In connecting medical knowledge with scientific knowledge, these medical practitioners, essentially early forensic psychiatrists, transformed deviant behaviour into mental illness. Furthermore, they argued, considering the intricacy of this new-found concept of mental illness, the meaning of an action can no longer be simply inferred from the action itself. What was necessary, they maintained, was expertise in interpreting how mental illness manifests itself in behaviour. The result was a profusion of medical theories of insanity that drew the courts into ever more subtle considerations and into an increasing dependence on technical literatures and persons with specialized training (Robinson 1996:155).

By the mid 19th century, psychiatry had become well ensconced in the courtroom and the concept of criminal insanity was constructed at the intersection of law and psychiatry. Successful mid 19th century insanity defences required that the defendant be shown to have been labouring under a "disease of the mind" as determined by a psychiatrist. At a criminal insanity trial, lawyers and doctors had become entwined to the extent that a determination of criminal insanity was not possible without participation of both parties. As Smith (1981:374) points out, even the term *criminal insanity* semantically encapsulates the overlap between legal and psychiatric discourses.

With its new found prominence within the 19th century courtroom, psychiatry achieved status as a field of knowledge able to decipher complex human behaviours. This ability shifted attention away from the act and on to the individual and the psychological characteristics (i.e., motives, intentions, will, tendencies, instincts, etc.) that constituted the individual as a criminal (Foucault 1978a). By focusing on inner psychological characteristics, psychiatric discourse provided an explanation for the seemingly unintelligible acts committed by the criminal. Increasingly, psychiatrists were called upon as experts in determining the motives of crime: "They had to evaluate not only the subject's reason but also the rationality of the act, the whole system of relationships which link the act to the interests, the plans, the character, the inclinations, and the habits of the subject" (Foucault 1978a:10). If it was determined that the individual acted in a way that was in keeping with their psychological organisation, the individual was thought to be responsible for his/her actions and was therefore culpable for the crime. However, if the crime was incongruent with the individual's psychological organisation, the act was seen as unintelligible and the individual was not held liable for the act. Individuals who found themselves in the latter set of circumstances were deemed not criminally responsible, labelled criminally insane, and transferred to the care and control of the psychiatrist.

A finding of criminal insanity highlighted the potential dangerousness or unpredictability inherent within the individual. Crimes that lacked reason, provided no forewarning, and made no sense signalled a perilous element at large in society. The psychiatrist, who claimed a specialized knowledge able to detect insanity, was seen as the riposte to this inherent societal threat. This established the symbolic association between madness and dangerousness, and the function of psychiatry as a type of 'hygiene' able to detect, cure and predict dangerous elements in society. Therefore, "19th century psychiatry was a medical science as much for the societal body as for the individual soul" (Foucault 1978a:7).

As Wiener (1990:85) observes, the 19th century insanity defence suggests a more humanitarian approach to mentally disordered offenders, but also, effectively ensured the custody of dangerous individuals, thus providing security to the public. While, *de jure*, a successful insanity defence meant that the defendant was relieved of criminal responsibility for the act, *de facto*, the individual was condemned to life imprisonment in the insane asylum. In this setting, in the 19th century, once again the fledgling discipline of psychiatry would become salient for individuals found criminally insane. Thus, in addition to providing expert testimony at an insanity defence, psychiatrists would also become the custodians of those adjudicated criminally insane.

The Insanity Defence and the Disposition of the Criminally Insane in Canada

This section provides a brief historical synopsis of the insanity defence and disposition of insanity acquittees in Canada from the mid 19th century to contemporary times. The aim is to describe what happens to a person found not guilty for reasons of insanity and outline how the discipline of psychiatry has come to be the primary actor in governing these individuals. This discussion provides the historical framework for the present study of the regulation of criminal insanity.

The history of the treatment of the criminally insane in Canada provides interesting, but often distressing, reading (see Chunn and Menzies 1998; Menzies 2002; Verdun-Jones and Smandych 1981). Before approximately the mid 19th century, criminal insanity acquittals were held in common jails with other prisoners. In the mid 19th century, one specially constructed asylum was provided for the criminally insane in Canada, located within the walls of the Kingston Penitentiary. However, there was little to distinguish the conditions or treatment of inmates in this facility from the penitentiary itself. Ironically, individuals who were relieved of criminal responsibility because of insanity suffered the same or often worse fate than those found guilty of their crimes. "In these circumstances, it is scarcely surprising that very few defendants in criminal trials were prepared to rely on the insanity defence during the nineteenth century. The defence appears to have been employed primarily as a means of evading the noose" (Verdun-Jones and Smandych 1981:103).

In 1892, Canada's first *Criminal Code* was enacted.[2] Section 11 of that *Code* provided that,

> *No person shall be convicted of an offence by reason of an act done or omitted by him when labouring under natural imbecility, or disease of the mind, to such an extent as to render him incapable of appreciating the nature and quality of the act or omission, and of knowing that such an act or omission was wrong.*

In Canada, at the end of the 19th century, a person found criminally insane was "to be kept in strict custody in such place and in such manner as to the court seems fit, until the pleasure of the Lieutenant-Governor is known" (55-56 V., c.29, s.736). In practical terms, an insanity acquittal provided for the automatic detention 'in strict custody' of the defendant in an asylum until the Lieutenant-Governor of the province saw fit that the person was released. This disposition was automatic and there was no formal process or procedure in law that would allow this person to be discharged. In reality, these individuals were held indefinitely in this 'strict custody' (Verdun-Jones 2002:228).

In the late 19th and early 20th centuries, with the development of provincially operated asylums, the federal government negotiated agreements with the provincial governments for the care of the criminally insane in these provincial institutions. This marked the beginning of a more specialized care in the hands of psychiatrists rather than the custodial care previously endured by inmates. Such specialized care took the form of a 'moral treatment' which attempted to re-socialise the person found insane.

It is surprising how little change occurred in the insanity laws in the years following the enactment of the first Canadian *Criminal Code*. From the years 1892 to 1968, the Criminal Code continued to address the disposition of individuals found criminally insane in a rather vague manner. In these years, insanity acquittees continued to be held "in strict custody" until Lieutenant Governor's "pleasure was known". In 1969, the Canadian government passed a statute that permits (but does not require) the Lieutenant Governor to appoint a board to review cases of those held in custody and advise the Lieutenant Governor (1968-69 (Can.) c.38, s.48). This Board of Review was to be chaired by a judge and include at least two qualified psychiatrists and at least one member of the bar of the province. The Board of Review's mandate was to review each case shortly after a finding of 'not guilty by reason of insanity' and thereafter on an annual basis. There were very few other procedural guidelines set out in the *Criminal Code* with regard to the operation of the Board of Review.[3] While the Board of Review's recommendations to the Lieutenant Governor were likely influential, it was strictly an advisory body, and there was no provision that the recommendations should or must be followed by the Lieutenant Governor (Verdun-Jones 2002:245). To be sure, the formation of panels whose task was to advise the Lieutenant Governor was a significant development in the governance of criminal insanity, as well as in the rights of those detained under insanity laws.

However, there was still no provision in law for the release of these individuals, except at the Lieutenant Governor's pleasure.

This situation was altered in 1972. In that year, the Canadian government added a statute (1972 (Can.), c.13, s.45) that officially provided for discharge of an insanity acquittee. This statute, for the first time in Canadian insanity laws, made it clear that the Lieutenant Governor may discharge from custody a person found not guilty for reasons of insanity if "it would be in the best interest of the accused and not contrary to the interest of the public". The Lieutenant Governor could make this discharge either absolute or subject to conditions.

The formation of review boards increased the accountability of the psychiatric system and the inclusion of discharge provisions increased the procedural options available to the Lieutenant Governor. While these developments enhanced the procedural safeguards in the detention of the criminally insane, the review boards were strictly advisory and the Lieutenant Governor was still given a very wide discretion as to place, manner and duration of committal of a person found not guilty for reasons of insanity. Within this system, the courts had no jurisdiction, on *habeas corpus*, to review, challenge, or reverse the exercise of this discretion. Ultimately, all persons found not guilty for reasons of insanity were automatically detained in the custody of a psychiatric facility until the "pleasure of the Lieutenant Governor was known". This indiscriminate detention became particularly relevant when the accused, while found insane at the time of the offence, subsequently recovered.

This was the crux of the issue in *R. v. Swain*, a recent case that fundamentally changed how individuals found criminally insane would be managed in Canada. In the *Swain* case (1991, 63 C.C.C. (3d) 481), the accused, apparently delusional at the time of the offence according to his victims, the psychiatrists who subsequently interviewed him, and even himself,[4] was transferred following arrest to a mental health centre where he was given anti-psychotic drugs. Thereafter, his condition improved rapidly and he was released pending his trial. At the trial, the Crown, against the wishes of the accused, raised the issue of Swain's sanity at the time of the offence. The trial judge subsequently found the accused not guilty by reason of insanity on all counts. Consequently, Swain was ordered to be kept in strict custody until the Lieutenant Governor's pleasure was known. The accused appealed the verdict of not guilty by reason of insanity to the Ontario Court of Appeal, but his appeal was dismissed. On further appeal to the Supreme Court of Canada, the court held that the way the Crown was permitted to raise the issue of insanity violated the accused's right to control his/her own defence. In addition, the Supreme Court held that the automatic detention of an insanity acquittee deprives him/her of the right to liberty and that such deprivation does not accord with the principles of fundamental justice. As a result of these findings the Canadian federal government was required to re-write the legal provisions regarding the insanity defence and, subsequently, in February 1992 Bill C-30 was passed.

Currently, Section 16(1) of the *Canadian Criminal Code* outlines the Mental Disorder Defence as follows:

> *No person is criminally responsible for an act committed or an omission made while suffering from a mental disorder that rendered the person incapable of appreciating the nature and quality of the act or omission or of knowing that it was wrong.*

Thus, a verdict of 'Not Criminally Responsible on Account of Mental Disorder' occurs when a judge or jury finds that the accused committed the act, but should be exempt from criminal responsibility for that act. In other words, in the opinion of the judge or jury a mental disorder prevented the accused from forming criminal intent (i.e., appreciating the act or knowing that it was wrong).

Not all individuals who raise the mental disorder defence are found Not Criminally Responsible. In Alberta, of the 138 individuals that were assessed for criminal responsibility in 2002 and 2003, 36 individuals (26%) were found Not Criminally Responsible (Derus and Gulayets 2004). That is, approximately one quarter of those individuals who raise the mental disorder defence are eventually found NCR. Across Canada, in 2000, 585 individuals were found NCR (Steller 2003). Nationally, approximately 0.15% of the total criminal code cases result in the Not Criminally Responsible verdict (Stellar 2003; Thomas 2002).[5] In Alberta, in 2000, 17 individuals were found NCR, which was approximately 0.03% of all federal statue cases in the province that year.

Along with a change in terminology from 'criminally insane' to 'Not Criminally Responsible', the new criminal insanity provisions introduced several other changes.[6] For example, under the new regulations, appeal of the disposition rendered is now possible (C.C.C., s. 672.72). Perhaps the most significant change is to the nature of the disposition of persons found Not Criminally Responsible.

After a verdict of NCR is rendered, the case is referred to a Board of Review that is responsible for granting a disposition concerning the individual found Not Criminally Responsible. With the passage of Bill C-30, the Board of Review of each province was elevated from a strictly advisory role to the sole adjudicator of the disposition of individuals found NCR. The Board of each province is comprised of at least five members, where one member is a judge who chairs the Board, at least two members are psychiatrists, and the remaining members are, most commonly, lawyers. The *Canadian Criminal Code* (s. 672.54) provides that one of the following dispositions be made following a ruling of Not Criminally Responsible:

a) if, in the opinion of the court or Review Board, the accused is not a significant threat to the safety of the public, the accused is discharged absolutely; or
b) the accused may be discharged subject to such conditions as the court or Review Board considers appropriate; or
c) the accused may be detained in custody in a hospital, subject to such conditions as the court or Review Board considers appropriate.

The *Canadian Criminal Code* instructs that a disposition be granted that takes into consideration the need to protect the public from dangerous persons, the mental conditions of the accused, the reintegration of the accused into society, and the other needs of the accused. In the case *Winko v British Columbia (Forensic Psychiatric Institute)*(1999), the Supreme Court of Canada ruled that detention under this Board of Review system is warranted only if the accused presents a significant criminal threat to society. An absolute discharge must be issued in cases where there is not sufficient evidence to establish a significant threat to the safety of the public. In addition, the law also states that the Board cannot impose a condition of psychiatric or other treatment upon the accused. Therefore, in order to receive treatment the individual found NCR must consent to it.

If the accused receives the first disposition listed above (item a), an absolute discharge is granted, and the individual is free to go with no conditions. If the accused receives the second disposition (item b), she/he is discharged to the community but required to follow certain conditions.[7] If the third disposition is rendered (item c), the individual is admitted to a psychiatric hospital and must follow certain conditions. The Board reviews the disposition and conditions placed on each individual at least every 12 months and increases or decreases these liberties until an absolute discharge is granted.

In Alberta, typically, an individual found Not Criminally Responsible will initially be detained in the inpatient facility. After a period of time, which varies for each person and is based on the perceived dangers that he/she poses, virtually everyone will ultimately be discharged to the community. The majority of these individuals will eventually be granted an absolute discharge. However, a small proportion will remain under the Board of Review system indefinitely. In a study of individuals found NCR in Alberta, Luettgen et al. (1998) report the mean length of time individuals remain under the Board of Review's purview was 7.4 years, of which an average of 3.8 years was spent as an inpatient in a psychiatric hospital. An equal amount of time (3.6 years on average) was spent as an outpatient discharged to the community.

In Alberta, if the accused is granted or attains the second disposition (discharge with conditions), she/he is required, through conditions set by the

Board of Review, to attend the forensic psychiatric outpatient clinic in Edmonton for regular appointments. At this clinic, the individual meets with and is examined by one or more psychiatric professionals and, as described in detail in the chapters below, is subject to a number of psychiatric practices and procedures. For some, this setting is the last step before absolute discharge. Others attend the clinic for a period of time, before being considered by the psychiatric professionals to be experiencing a relapse in their illness, and find themselves returned – either voluntarily or involuntarily – to the hospital as an inpatient. Others attend the clinic in perpetuity.

As we see by comparing earlier versions of the *Criminal Code*, the possible dispositions now available to a person found Not Criminally Responsible are dramatically different as a result of Bill C-30. The late 19th century provided the rather opaque and terse disposition of strict custody until the pleasure of the Lieutenant Governor was known. In contrast, by the late 20th century, clear guidelines are in place which direct that a Board of Review evaluate each case shortly after the finding and thereafter on an annual basis. The Board of Review is to make a disposition that is least onerous and least restrictive to the accused and take into consideration the accused's mental condition and reintegration into society, as well as the need to protect society (C.C.C., s. 672.54). Unlike the inevitable and indefinite confinement of the previous century, there are now three possible dispositions that can be made: 1) detention in an inpatient setting; 2) discharge to the community; and 3) absolute discharge. The first two dispositions are accompanied with conditions, the third is not. Under the new law, indefinite detention without regular review is no longer possible, automatic detention is no longer a certainty, and the supervision of the criminally insane in the community becomes not only a possibility, but, for the majority of patients, the preferred situation. This transformation from "strict custody" to "least onerous and least restrictive" disposition clearly demonstrates a changing attitude toward the rights of mentally disordered offenders. This attitude also indicates and necessitates changing modes of regulation of criminal insanity.

In sum, this chapter frames the study of the governance of individuals found Not Criminally Responsible. While the main focus of this study is the micro-political forms of regulation encountered at a forensic psychiatric outpatient clinic, at a broader level, historical and legal conditions define how individuals arrive at the clinic and, to a large part, structure their day-to-day activities while under the Board of Review system.

Chapter Three – Theoretical Framework

This chapter provides the broad theoretical framework for this research project which is informed by the scholarship of Michel Foucault and Erving Goffman. As discussed below, Foucault and Goffman provide different but complementary perspectives on the conceptualization and governance of insanity. The present chapter considers both Foucault's and Goffman's contributions to the conceptualization of insanity, while the following chapters focus specifically on how criminal insanity is governed in a forensic psychiatric outpatient clinic.

The first section of the chapter situates this study as a synthesis of the work of Foucault and Goffman. After a brief discussion of each scholar's approach to the theoretical concept of power, it turns to Foucault and Goffman's studies of insanity. Put simply, Foucault approaches the topic of insanity from an historical, socio-political perspective (i.e., a macro perspective of power relations), while Goffman explores the interpersonal, face-to-face interactions that occur in institutional settings (i.e., a micro perspective). These two approaches guide the present study of criminal insanity.

The final section examines criminal insanity in relation to liberal forms of governance (i.e., a broadly Foucauldian, macro perspective). The argument developed here is that the identification and regulation of criminal insanity reflects wider modes of socio-political governance. However, as documented in the ensuing chapters, current modes of governing criminal insanity do not sit entirely within either liberal or advanced liberal governmentality, nor do the current modes of governance reflect an unproblematic shift from liberal to advanced liberal governmentality. Rather, the forms of governmental rationalities and techniques put into practice in the community forensic psychiatric clinic represent an open-ended process that incorporates shifting, volatile and precarious modes of governance in complex, often shambolic, processes.

Foucault and Goffman – Theoretical Anchors

In contemplating criminal insanity from both the macro and micro perspectives, I take inspiration from Ian Hacking who in a series of studies (e.g., 1995; 1998; 1999) examines the process of "making up people". By this, Hacking means how people are classified, how we classify ourselves and the interaction between these two phenomena. Specifically, Hacking (2004:287) asks, "How is the space of possible and actual action determined not just by physical and social barriers and opportunities, but also by the ways in which we conceptualize and realize who we are and what we may be, in this here and now?".

As Hacking suggests, there are two ways of 'making up people': first are the historical and conceptual features which shape our existence; and second are the immediate physical and social settings which frame social interaction. Hacking (2004) avers that these two perspectives are represented by, respectively, Michel Foucault and Erving Goffman. While often seen as dramatically opposed, Hacking suggests that the scholarship of each of these men is complementary – each provides what the other lacks. Foucault's archaeologies and genealogies describe how "historical settings work on people to form their potentialities, but never indicate how this happens in daily life. Goffman does that in rich detail, but gives no hint of how the surrounding structures themselves were constituted" (Hacking 2004:288).

Foucault and Goffman clearly come from different epistemological and ontological perspectives. As discussed above, epistemologically, Foucault focuses on broader, socio-political themes, while Goffman focuses on micro, interpersonal interactions. Ontologically, Goffman studied interactions as a method of exploring how the individual presents the self. Thus, Goffman could be classified as a humanist focused on the relation of the self to the interaction order (see Goffman 1959). Foucault, on the other hand, rejects humanist ideals of truth, reason and human nature. Foucault's early studies in particular view the subject as a construction of various discourses or modes of knowledge such as the human sciences and medicine (see Foucault 1970).

While the theoretical approaches of these two scholars diverge in significant ways, there are also key meeting points. For example, both are analysts of social institutions. Also, for both Foucault and Goffman, power is articulated through interpersonal relations. However, from these meeting points, each moves in different but, as Hacking asserts, complementary directions.

For Foucault, power is not to be thought of as a group of institutions and mechanisms of a given state; nor as a mode of subjugation which has the form of rule; nor a general system of domination exerted by one group over another. As Foucault (1978b:92) puts the matter, "the analysis, made in terms of power, must not assume that the sovereignty of the state, the form of the law, or the over-all unity of a domination are given at the outset; rather, these are only the terminal forms power takes". For Foucault, power does not exist in the substantive sense. It does not emanate from a certain location, nor is it possessed by any one person, group or class. Rather, Foucault encourages us to view power as present in all forms of social relations and "employed and exercised through a net-like organisation" (Foucault 1980a:98). Individuals circulate within this 'net-like organisation' and do not possess power, but are rather always simultaneously undergoing and implementing this power. Individuals are thus not just the targets but also the vehicles of power (Foucault 1980a:98). In short, for Foucault, power refers to the forces that operate whenever and wherever social relations exist. Power is ubiquitous in all interpersonal interactions – no social interaction is outside power relations and, likewise, all social interactions are power relations. The goal of analyses, therefore, becomes the identification of *how* power is practised through 'the visible' and 'the sayable', rather than the identification of *what* power is.

While Goffman is not generally considered a theorist of power, nor does he directly address the issue at length, Rogers (1977, 1980) demonstrates that Goffman's analyses do provide implicit insights into the concept of power. In his analyses of face-to-face interactions, Goffman illustrates how individuals affect one another. Goffman (1959:6) argues that individuals display varying degrees of *intentionality* in affecting other individuals. At one end of the continuum, individuals may unintentionally or unwittingly influence the behaviours of others. For example, through factors such as body language, facial expressions or the relative social positions of the interactants, one individual can influence the behaviour of the other. At the other end of the continuum, individuals choose certain modes of behaviour as means to achieve interactional goals. Goffman (1969) labels this *strategic* interaction. This type of interaction is relatively one-sided, with one person intentionally attempting to influence the behaviour of another. The modes of behaviour that an individual chooses in order to influence another can range from gestures, to verbal communication, to strategies that involve rewards or sanctions. The goal of such interpersonal interactions is to derive a specific, or preferred, outcome.

Whether the interactional behaviours are unintentional or intentional, the individual's success in social interactions depends on each party's differential capacities to affect others' behaviours. In other words, Goffman approaches power as a resource related to the capacity or potential to affect others' behaviour (Rogers 1980:104). Simply, those with greater capacity to affect others are more likely to reach their desired interactional outcomes than those with lesser resource capacity. For Goffman the goal of analyses is to identify the modes of interpersonal interactions that result in specific outcomes or behaviours.

In sum, both Foucault and Goffman view power as a potentiality which is made possible through or manifests itself with interactions between individuals. Foucault's analyses take a broader focus emphasizing the socio-political conditions that structure interpersonal interactions, whereas Goffman's analyses take a narrower focus scrutinizing the actions and behaviours of individuals.

Foucault, Goffman and 'Making Up' Insanity

In 1961 both Foucault and Goffman published important studies of mental illness. Despite the common subject matter, Foucault's *Madness and Civilization* and Goffman's *Asylums* highlight the divergent analytical foci taken by each scholar. Foucault's study concentrates on the bifurcation of madness and reason from the end of the middle ages to the 19th century. His thesis is that during this period, madness is progressively distanced from its association with spiritual or demonic possession, but increasingly is seen as a physical and moral malady. Insanity becomes identified through the failure of individual reason and rationality – a viewpoint still dominant today. By the 19th century madness becomes an object of medical discourse which classifies it as a pathology or disease. This perspective creates the conditions for insanity to be 'treated' through the burgeoning discipline of psychiatry with its focus on therapeutic techniques based in scientific and normative reasoning. Foucault's objective in this study is to analyse the historical and socio-political conditions that gave rise to how madness came to be characterized as the lack of reason. In short, Foucault provides a macro view of how insanity is 'made up'.

Goffman's study, on the other hand, provides an analysis of everyday social interactions that occur within contemporary institutions. Specifically, he examines the interactions between patients and medical staff in a psychiatric hospital where the capacities between interactants are relatively asymmetrical. Goffman focuses on the formation and presentation of self as shaped through institutional practices and interactions. He characterises as 'total institutions'[1] those places where coercion changes people, either in intended or unintended directions. He demonstrates that individual behaviour is a product of both formal, intentional regulatory procedures which impose institutional rules and norms over individuals, and also less formal, often unintentional, social interactions between participants. Goffman meticulously documents how both face-to-face encounters and institutional rituals affect people's behaviour, as well as shape the formation of self. In short, Goffman provides the micro view of how insanity is 'made up'.

While neither Foucault or Goffman offer detailed discussion of *criminal* insanity, both of their perspectives shape the current project. The remainder of this chapter provides the historical and socio-political perspective on criminal insanity (i.e., a Foucauldian reading), while the subsequent chapters focus on how interactions between psychiatric professionals and individuals found Not Criminally Responsible 'make up' the concept of criminal insanity within the context of specific governmental regimes.

Liberalism, Advanced Liberalism and Criminal Insanity

The following discussion ties the genealogy of criminal insanity to the genealogy of liberalism. The objective here is to demonstrate that transformations in how criminal insanity is governed reflect socio-political themes. In other words, liberal modes of governance are reproduced by the ways criminal insanity is regulated.

Liberalism

As noted in the previous chapter, in Canada in the 19th century those deemed criminally insane were held in prisons or in asylums within penitentiaries.

By the early 20th century, the criminally insane were sent to the newly established psychiatric hospitals. This specialized care of the criminally insane in the early to mid 20th century is representative of liberal forms of governance.

Liberalism forms distinctive governmentalities best epitomized by what Foucault refers to as the 'mechanisms of security' (Gordon 1991:19-20). Liberalism advises that security is best achieved by establishing mechanisms that permit and ensure economic forms of government. Within liberal governmentalities, 'economic' refers both to the efficient management of conduct, as well as a field of intervention in relation to markets and commerce. These mechanisms or governmental technologies ensure the security of the state *through* the health and wealth of its citizens. Liberal 'mechanisms of security' include the effective management of the national economy (e.g., stable currency and trade relations), as well as social systems that promote the well being of citizens through health, education, insurance, and other forms of state-sponsored schemes.

Through the 19th to the mid 20th century, the mechanisms of security established the conditions for the development of the burgeoning disciplines of the social sciences (e.g., psychology, social work, economics, political science). For example, governmental mechanisms came to rely on *expertise* ascribed to certain individuals based on specialized 'truths' or knowledge that they are seen to possess. In this manner, the authority of expertise becomes linked to political rule, and governmental rationalities are therefore able to operate inconspicuously and at a distance. In other words, liberal governmental power flows through – and acquires its effectiveness from – the network of professional social settings (e.g., hospitals, schools, social work offices, juvenile courts, clinics, etc.) which concentrates professional powers and acts as a centre of governance (Garland 1997:179). In this form of liberalism, commonly referred to as 'welfarism',[2] these disciplinary forms of expertise become inextricably linked to the political forms of rule in attempts to govern the undesirable consequences of industrial life, wage labour and urban existence (Rose 1993:285). In other words, 'the social'[3] becomes the object of government. And, unlike the direct forms of governance utilized by the centralized state, the welfare state regulates persons and activities through these 'social' forms of government.

Under liberal government, the individual emerges as a 'subject of interest' (Gordon 1991:21); one that is characterized, not as an acquiescent subject as in social contract theory, but rather as an individual who possesses preferences and choices that are irreducible and non-transferable.[4] These preferences and choices symbolize a potential or capacity within the individual. The objective of liberal governmentalities is not to create capacities, but rather to *manipulate and cultivate* pre-existing capacities within subjects (Ransom 1997:31; Rose 1999a:4). Therefore, within liberalism, to govern is to presuppose and utilize the capacities of the subject to promote compliance with initiatives, avoid dissent, and ultimately to achieve certain goals.

In this context, criminal insanity was seen as a failure of liberal rationality. This failure occurs on two fronts. First, individuals found criminally insane fail as juridical subjects (i.e., they don't act rationally) and second, they fail as social subjects (i.e., they don't act normally). As a consequence, individuals found criminally insane were institutionalized and faced psychiatric disciplinary tactics. These techniques ranged from psychotherapy to shock therapy; from cold water dousing to psychotropic medications (LaJeunesse 2002). The aim of these treatments was to encourage individuals to discipline themselves in accordance with moral and behavioural standards of the day in the hope that they could be returned to a state of 'rationality' and 'normality'. When it was felt that the individual achieved this level of socialization, he or she was released from the asylum. In reality, in the first half of the 20th century, very few individuals found criminally insane were ever released.

Advanced Liberalism

By the last two decades of the 20th century, the welfare state was coming under a wide range of criticism for being costly, overly bureaucratic, indiscreet in granting authority to unaccountable professionals, paternalistic, engendering inequality and crushing autonomy (Rose 1993:294). What emerges from these criticisms are *technical* (i.e., governmental) solutions to 'the social' space governed by liberal mentalities. (See Smandych (1999) and Stenson & Sullivan (2001) for discussions of advanced liberal forms of governance in relation to crime and criminal justice.)

This advanced liberal form of rule seeks to restructure both the mentalities and the domains to which government must address itself. For example, neo-liberal mentalities are advanced according to a particular economic rationality – the market. By the end of the 20th century, neo-liberal technologies, such as privatisation, competition, enhancement of the powers of the consumer, financial accountability and audit, are common place. Markets are seen as the ideal mechanism for the automatic co-ordination of the decisions of a multitude of individual actors in the best interest of all (Rose 1999a:146).

Likewise, the territories of governance are also shifting. Whereas 'the social' represents a circumscribed space (e.g., the asylum, the school, the factory) the territories of advanced liberalism become increasingly fragmented. This fragmentation is best exemplified by the notion of community (Pavlich 1996; Rose 1996a). Rather than the single, interlocking network that encompasses 'the social', advanced liberalism governs a wide diversity of communities based on many different, but often overlapping, features, such as: geography, culture, sexual preference, illness, risk factor, religion, and so on. Thus, we may talk of native communities, an AIDS community, criminal communities, or a community of individuals found NCR – the possible number of communities is virtually limitless.

Advanced liberal governmentalities signal a significant shift in political rule. The state is recast from the guarantor and provider of security to the role of facilitator of independent agents who must seek out their own security. Whereas, liberal governance acts from 'above' through a series of authorities and expert knowledges, advanced liberal governance acts from 'below' through the decisions made by the individual/consumer. Rose (1996a:328) suggests that "we are seeing the emergence of a range of rationalities and techniques that seek to govern without governing *society*, to govern through regulated choices made by discrete and autonomous actors in the context of their particular commitments to families and communities". In other words, instead of acting through society, this emerging form of governance operates by shaping and utilising the freedom of actors. In consequence, the 'social state' is increasingly no longer responsible for all of society's needs for order, security, health, prosperity, and such. Individuals, parents, communities, organisations, and other autonomous entities must act entrepreneurially and take on the responsibility for their own well being (Rose 1999a:142).

With the development of advanced liberal governmentalities – such as competition, privatization, enhancement of the powers of the consumer, etc. – the subjects of rule emerge in new forms. For example, as opposed to liberal governmentalities which attempt to govern through the 'social space', advanced liberal governmentalities attempt to govern through the regulated choices of the individual/consumer. For this latter type of governance, the manipulation of capacities and the presumption of freedom is even more salient. Liberal governance in the form of, and working through, social solidarity gives way to a form of governance where subjects are to govern themselves in an individualised, responsibilised, and entrepreneurialised manner (Rose 1999a: 139). Aspects of social behaviour are reconceptualised along economic and market mentalities. Individuals must choose and are responsible for their own decisions and conduct.

O'Malley (1992:257) has termed this form of subjection *prudentialism,* which he defines as a privatized actuarialism. Whereas liberal mechanisms of security – social insurance, welfare, etc. – function through the 'social space' in an attempt to disperse the risks of social life, advanced liberalism shifts the emphasis to the individual/consumer who must take an active role to ensure his/her own security. Through this privatization of risk management, the individual must add "to his or her obligations the need to adopt a calculative and prudent personal relations to risk and danger" (Rose 1993:296). Advanced liberal governmentalities thus work to empower the individual in making rational, responsible, prudent choices which will subdue risks and provide security.

Advanced Liberalism and Criminal Insanity

If psychiatry came to prominence in the 19th century as a reaction to the dangers inherent in the social body (Foucault 1978a:7), psychiatry today is prominent in governing criminal insanity because of its ability to adapt to changing socio-political conditions. Forensic psychiatry should no longer be seen exclusively as 'keepers' of the criminally insane, but now as 'administrators' of a wide variety of governmental rationalities and technologies.

Specifically, new governmental technologies become important in governing criminal insanity in the outpatient setting. For example, as will be discussed in the chapters below, within community forensic psychiatry we see the dispersal of activities that were once the exclusive domain of psychiatric professionals. Family members, group home operators, neighbours and employers now become involved in the therapeutic activities and surveillance of individuals found NCR. For example, these 'non-professionals' engage in monitoring and documenting behaviour, ensuring medications are taken, providing guidance and support, and assessing risk. Another advanced liberal development is the involvement of patients in their own care. For example, as discussed in the next chapter, regular meetings take place between the psychiatric professionals and the patient in order to devise 'Individual Care Plans' in which mutually agreeable objectives are established for the patient who then sets out to achieve these goals.

As demonstrated in this example, *self governance* becomes a critical component in the care and control of individuals discharged to the community. As Lacombe (1996) emphasizes, the analysis of power strategies must move beyond an essentialist reading where all governmental tactics result in systems of domination. Instead, she stresses, we must look to power as a strategy that *both* constrains individuals through mechanisms of objectification as well as enables individuals to constitute themselves through a process of subjectification. This is a theme I take-up in detail in Chapter Eight.

The strategies of regulation that individuals found Not Criminally Responsible face are indicative of advanced liberal modes of rule. Rose (2000) describes contemporary control strategies as existing within both 'circuits of inclusion' and 'circuits of exclusion'. The control mechanisms which Rose describes as 'circuits of exclusion' are typified by disciplinary forms of control, such as inpatient confinement within a psychiatric institution. The goal of this form of social regulation is either to rehabilitate the inmate in order to reaffiliate the subject back into civil society, or, for those cases that will not or cannot be rehabilitated, to neutralize the dangers they pose through more austere control strategies. In addition, contemporary control mechanisms can work within 'circuits of inclusion'. Regulation within these forms of practices "is not centralized but dispersed, it flows through a network of open circuits that are rhizomatic and not hierarchical" (Rose 2000:325). Control mechanisms within circuits of inclusion work through diverse networks of community that continually monitor and reshape conduct, but are also constantly encouraging subjects to self govern and take responsibility for their own lives.

Therefore, these different forms of control strategies work towards different goals. The goal of exclusionary forms of regulation, characterised by inpatient settings, is to attempt to construct a subject who is respectable. In contrast, the goal of inclusionary forms of regulation, characterised by outpatient settings, is to create a subject who is responsible. Individuals found Not Criminally Responsible who reside in the community are in a liminal position – that is beyond the immediate circuits of exclusion, but not yet completely within the circuits of inclusion. Thus, individuals found NCR who have not yet been granted absolute discharge are in a 'transfer region' between one circuit of control and the other. Here, forms of exclusionary regulation are still salient as the individual faces disciplinary tactics, however, inclusionary regulation tactics such as self-governance become extremely important. As instructed by the *Criminal Code*, these individuals must be governed through means that are 'lest onerous and restrictive', balancing the rights of the individual with the security of society. This happens through a complicated mix of rationalities and techniques.

In sum, this thesis examines power relations as they occur in the context of this case study and analyses them against the postulations of advanced liberalism. Specifically, it investigates the rationalities and techniques by which psychiatric professionals attempt to govern the conduct of those found NCR, and also how individuals found NCR self-regulate or govern themselves. This focus engages both the macro-level, socio-political factors that play a role in the construction of criminal insanity and the micro-level, interpersonal interactions that guide day-to-day practices regulating those found criminally insane. This thesis contributes an empirical component to the governmentality literature as well as a novel and unique approach to the study of criminal insanity.

The following chapter provides a discussion of the methodology used in this project, while the ensuing chapters analyse how the criminally insane are constituted as subjects through various practices such as surveillance, risk, resistance and forms of self-governance.

Chapter Four – Methodological Framework

This chapter focuses on the methodological framework of this project. It includes specific discussion of the research method, setting, participants, and data collection opportunities and procedures. The chapter concludes with ethical considerations and reflections on the research process.

The goal of this research is to gain a better understanding of how individuals found Not Criminally Responsible are regulated within a forensic psychiatric outpatient setting. I approach the types of regulation as forms of governance. To achieve this goal, I observed the interactions between individuals found NCR who are mandated to attended an outpatient clinic and psychiatric professionals who are employed within this clinic. In essence, this is a case study exploring modes of governance in a particular setting. The objective is not to develop generalizations about how criminal insanity is governed in *all* forensic psychiatric outpatient clinics, but rather to explore regulation in a particular setting and how it relates to wider shifts from liberal to advanced liberal governmentality. Thus, the aim is a sociological appraisal of the implications of governmental rationalities and techniques in a particular *situation*, not a phenomenological study of the *experiences* of individuals involved in this system. In short, this case study endeavours to gain a greater understanding of the dynamics of governance in a particular social setting.

Case Study Approach

The case study is a foundational method in sociology. According to Yin (2003:13), "a case study is an empirical inquiry that investigates a contemporary phenomenon within its real-life context, especially when the boundaries between phenomenon and context are not clearly evident". Yin elaborates that the case study method is advantageous when "how" or "why" questions are being asked about a set of events or context over which the investigator has little control. For the present purposes, the case study approach offers the ability to observe and assess how advanced liberal modes of governance are replicated within a particular setting.

Robert Stake (2005:443) asserts that "the case study is not a methodological choice, but a choice of what is to be studied". From this perspective, the case is a functioning, specific, bounded social system. It is the unit of analysis that has both a specific focus (i.e., what will be studied) and a boundary that defines the periphery of the case (i.e., what will not be studied) (Miles and Huberman 1994).

Within this research project, the case under examination is the forensic psychiatric outpatient clinic located in Edmonton, Alberta. This specific case study is bounded in several ways, including by place, time and participants. First of all, the study is restricted to one location, focusing on the governance of individuals within this unique physical location. In Alberta, the vast majority of those discharged to the community must regularly attend this particular clinic, as outlined in the conditions imposed by the Board of Review.[1] These individuals are, of course, governed through other relationships, settings and contexts that are outside of the boundaries of this particular site and thus outside the parameters of the study (e.g., family, employment, etc.).

This study also has a temporal limit. This site was studied between September and December 2005, and, as such, the exact implications of this study are limited to this timeframe. However, since psychiatric forms of governance do not usually shift rapidly, this timeframe could be regarded as more generally typical of practices within this setting.

Finally, this study focuses on individuals found NCR who are conferred the specific legal disposition of 'conditional discharge'. This disposition allows individuals to live in the community under specific legal conditions. I do not examine the governance of those who are detained in a psychiatric inpatient facility, nor do I consider how individuals are governed once granted absolute discharge from all legal dispositions.

This case was not selected necessarily for its representativeness of a general population, but rather for its potential to reveal the manifestations of abstract principles, theoretical precepts and governmental technologies. Stake uses the term 'instrumental case study' to describe a study that provides insight into an issue or redraws a generalization. "The case is of secondary interest, it plays a supportive role, and it facilitates our understanding of something else" (Stake 2005:445).

Therefore, on one hand, this particular case is neither necessarily unique nor representative of a general population. It is bounded by a specific physical location and time frame, and only particular participants were studied. On the other hand, the in-depth understanding of this forensic psychiatric outpatient clinic, its activities, interactions and operation, plays an instrumental role in gaining insight into the regulation of criminal insanity and the situation of those found Not Criminally Responsible. In short, the study of this particular case provides, first, an empirical component to the governmentality literature; second, a deeper understanding of situations of individuals found NCR who are discharged to the community; and third, an evaluation of the theoretical presuppositions of the shift from liberalism to advanced liberalism.

Data Collection

The method of data collection entailed a form of participant observation. This strategy requires the researcher to directly observe and participate within the research setting. The objective of observational methods is to encounter the participants and setting up-close and first-hand, and, specifically for this project, to explore, understand and interpret the processes involved in the regulation of criminal insanity. This approach focuses attention on context and interactions, and attempts to capture the unique character of the setting. To analyse the modes of regulation that govern criminal insanity in a forensic psychiatric outpatient clinic, I observed the social interactions that occur between patients and psychiatric professionals.

I had exceptional opportunities and extraordinary access to the research site. I worked at this forensic psychiatric outpatient clinic for approximately 15 years, including the period during which data collection occurred. However, I never worked directly with individuals found Not Criminally Responsible. Therefore, my position in this research process is mid-way between the two poles of participant observation. On one hand, because I was not a member of the psychiatric team that deals with these individuals (and I have never been found Not Criminally Responsible), I was not a full participant in this setting. On the other hand, because I made the reason for my presence known to all participants, my involvement was not exclusively observational. In other words, I was not a full participant of the setting, but neither was this research purely observational or covert.

There are several features of this strategy that made it ideal for this project (Patton 2002:262-4). For example, through direct observation, investigators can better understand and capture the context in which participants interact. This first hand experience requires the investigator to remain discovery-orientated and open to all aspects of the setting. It also encourages an inductive approach that challenges researchers to constantly problematise what they encounter in the setting. Researchers draw on their personal interpretations of the context as well as the interpretations of participants. In addition, participant observation may also reveal elements that escape or go unnoticed by members of the setting, or uncover elements that members are not willing to talk about or reveal using other data collection methods such as interviews.

Such an approach does however raise specific issues about the research setting, research participants, collection of data, and analysis of data, as discussed below.

Research Setting

Forensic Assessment and Community Services (FACS) is the forensic psychiatric outpatient clinic associated with Alberta Hospital Edmonton, a psychiatric treatment facility that serves Northern Alberta, the Yukon and the Northwest Territories. The outpatient clinic is the main location in Alberta where individuals found NCR must attend when discharged to the community.

The outpatient clinic occupies the eighth and ninth floors of an office building in downtown Edmonton. The eighth floor contains the reception area, a file room, approximately 30 staff offices, a conference room and the medication room. The ninth floor includes four group therapy rooms and the occupation/recreational therapy area.

To access the clinic, individuals must take an elevator to the eighth floor, which brings them directly to the reception area which seats approximately 20 individuals. The chairs in the reception area are constructed of metal pipe and grate and are purposely designed to be uncomfortable, to discourage lounging, reclining and/or loitering. Access to areas beyond this outer reception area is restricted by locked doors. Staff members have free access to the inner offices; however, patients of the clinic must wait until escorted by a staff member to the interior offices.

Most of the interactions observed for this research project took place in the interior section of the eighth floor. For example, interactions that involved more than three individuals usually took place in the conference room. This large room contains approximately 40 chairs, but individuals meeting here would typically pull chairs to the centre of the room and form a circle. On one wall of the conference room hangs a large whiteboard.

Interactions involving only two or three individuals usually took place in a staff member's office. Each office contains a desk, a few chairs, and other standard office equipment, such as a filing cabinet and bookshelf. Offices are individually decorated with plants, posters, or academic degrees.

The medication room contains two medical examination tables, a counter with sink, a locked cabinet containing psychiatric medications and a refrigerator also containing medications. This room is most commonly used by nurses to administer psychiatric medications via injections, however, on rare occasions, a psychiatrist might use the room to perform a medical examination.

The ninth floor is accessed by stairs from the eighth floor. A locked door at the top of the staircase means that patients must be escorted or allowed access to the ninth floor by a staff member. On the ninth floor, there is one large group therapy room that accommodates approximately 50 individuals. The other three group therapy rooms accommodate approximately 20 individuals each. The occupational/recreational therapy area contains approximately six large folding tables with chairs, several computer stations, and a kitchen area.

Research Participants

All individuals found Not Criminally Responsible and all staff members who provide psychiatric care for these individuals were considered eligible to participate in this study. Participant observation was carried out with the knowledge and permission of all participants. I did not exclude any potential participants from this study unless they indicated that they did not wish to be observed, in which case I respected their wishes.

Patient-Participants At the beginning of the data collection period there were 70 individuals found NCR in Alberta who were discharged to the community and subsequently required to attend the clinic on a regular basis.[2] Of these 70 individuals, 14 were women and 56 were men. Of this total population, 31 individuals found NCR were approached to participate in this research project. Twenty six men and two women consented to participate, while three individuals (all men) declined participation. In addition, three family members (two mothers and one father) of individuals found NCR also consented to participate.

There is a slight under-representation of women in this study. As noted, two of the 14 women discharged to the community participated in the study. Several factors coincided during data collection which may account for this under-representation of women. For instance, a couple of the women were temporarily re-admitted to the inpatient facility during the data collection period, but were still considered to retain a conditional discharge. Another woman and her psychiatrist communicate in a language other than English, which I am not able to understand. Finally, a psychiatric professional requested that one female patient not be approached to participate as it would be clinically contraindicated.

In addition, there were no Pre-Board conferences or Individual Care Plan meetings (described below) scheduled for women during the data collection period. As a result, I did not observe interactions between psychiatric professionals and female patients in these types of interactions. However, I did observe several clinical appointments and a family therapy session involving women found NCR. In addition, all women found NCR were discussed by the staff members at the case conferences.

While this juxtaposition of factors was unfortunate, even with a small number of women participants, I was able to discern some gendered dynamics, outlined below, which certainly indicate rich opportunities for further study.

Staff-Participants Twelve staff members participated in this research project. There are 10 psychiatric professionals who deal mainly with the individuals found NCR (i.e., two psychiatrists, one psychologist, three psychiatric nurses, one social worker, two occupational therapists, and one recreation therapist).[3] Most of these individuals deal nearly exclusively with individuals found NCR; however, some of these professionals deal with other offender types also referred to the clinic. These professionals are divided into two treatment teams. Each psychiatrist heads one of the treatment teams. All other professionals are members of both teams. Also participating in this research were the Forensic Psychiatric Clinical Director, who is the head psychiatrist overseeing both the inpatient and outpatient facilities, and a Psychiatric Resident, who was completing a residency placement at the outpatient clinic during the period of data collection. Of the 12 psychiatric professionals, five are women and seven are men.

Data Collection Opportunities

The aim of this research project is to examine the governmental rationalities and practices utilised in the regulation of criminal insanity. I endeavoured to achieve this objective by observing the interactions between psychiatric professionals and individuals found NCR, and between staff members.

There are numerous psychiatric practices and procedures, both formal and informal, in which these various interactions take place. Table 1 below briefly describes these interactions, while the sections that follow provide detailed discussion. These procedures are the primary sites of interaction between participants and will be referred to throughout this document.

Table 1. Types of Interactions Between Participants

	Description	Participants
Clinical Appointment	Brief (e.g., 20 minute), usually weekly, face-face meeting between patient and psychiatric professional	Individual found NCR, one (sometimes two) psychiatric professional(s)
Case Conference	Weekly meeting in which all individuals found NCR are briefly discussed; focus is on current circumstances of patient	Psychiatric professionals only
Pre-Board Conference	Annual meeting for every individual found NCR to discuss with staff progress or concerns from the past year; Psychiatrist submits an annual report to the Board of Review based on this meeting; focus is on past behaviour of patient	Individual found NCR, psychiatric professionals, Forensic Clinical Director
Individual Care Plan Meeting	Annual meeting for patient and staff to establish therapeutic direction and goals for the upcoming year; focus is on future course of action regarding the patient	Individual found NCR, psychiatric professionals
Family Therapy Session	Psychotherapy session usually conducted by psychiatrist but also involving other psychiatric professionals	Individual found NCR, family member(s), psychiatric professionals

Clinical Appointments A ubiquitous condition of discharge to the community is regular (usually weekly) attendance at the forensic psychiatric outpatient clinic. The goal of the clinical appointment is to provide recurrent monitoring of individuals found NCR who are discharged to the community. Clinical appointments are brief, private, usually informal discussions between a psychiatric professional and patient that usually take place in the staff member's office. Most appointments take between 15-20 minutes. Most commonly, the patient sees a different member of the treatment team on each visit to the clinic. There are 'NCR clinics' on Monday afternoon (for one psychiatric team) and Tuesday afternoons (for the other team) where the patients are seen on a first-come-first-seen basis by the next available NCR staff member. Patients who are not seen during the clinics are scheduled for other times of the week, which may include meetings after regular office hours, or even a NCR team member visiting the patient's home. The psychiatrist sees each patient individually approximately once every few months, or more often if there are concerns about the patient or the psychiatric medications that the patient is taking.

Typically, the staff member goes to the reception area, calls the next patient, and the two proceed to the staff member's office. Inside the office, the staff member sits behind the desk and the patient sits at a chair beside the desk. I sat in a chair that was often in the corner of the office facing both the patient and therapist, or in some offices, in a chair adjacent to the patient facing the therapist.

Most patients appeared comfortable in this type of interaction. Many have experienced scores of these appointments – some individuals have had weekly, or some cases, daily appointments for many years. While each staff member conducts the appointment in a slightly different style, and each patient brings differing issues to the appointment, all clinical appointments follow a certain rhythm. A common format is for the interview to begin at a superficial level, with discussion about sports, movies, the weather, and so on. At some point, the discussion turns to more serious topics. Every clinical appointment includes discussion about the patient's psychiatric condition, such as symptoms of mental illness, psychiatric medications, and side effects of medications. Other more general issues are also usually discussed (e.g., employment, group homes, family relations, etc.). Typically, the psychiatric professional asks questions and the patient provides answers. In some clinical appointments, the patient directs the conversation, bringing up topics or concerns before being asked about them. During the conversation, the staff member might look through the patient's file for some detail or make notes in the file. When the psychiatric professional is satisfied that the appointment has taken into account all the necessary topics, the appointment concludes and the patient is escorted either back to the elevator area or to the medication room for an injection of psychiatric medication. The most commonly administered medications are anti-psychotic, anti-depressant, anti-anxiety and/or side-effect control medications. Following the clinical appointment, the staff member will take a few minutes to document the meeting on a form that is subsequently placed in the patient's file. The comments made by staff can range from a brief summary of the highlights of the interview to detailed notes on the appearance and demeanour of the patient and the contents of the discussion.

Case Conferences Each NCR team holds a case conference once per week. This meeting provides the opportunity for staff to briefly discuss every individual found Not Criminally Responsible. The goal of the case conference is to ensure that all staff members have, at minimum, a passing familiarity with the circumstances, concerns or issues of each individual. Both inpatients and outpatients are discussed, as well as individuals who have been granted an absolute discharge but still maintain contact with the psychiatric team. The list of names can range from 50 to 75 individuals for each of the two treatment teams.

On occasion, the case conference begins with discussion of a pressing matter concerning a particular patient. Otherwise, it starts with a 'roll-call' where one staff member reads the names of each individual found NCR and the other staff members make comments about the patient. The majority of names are responded to with comments such as: "Fine", "OK", "Same", or the like, but sometimes more details concerning a patient are provided by one or more staff members. At most, a particular individual is discussed for a few minutes. Most case conferences last approximately one hour.

Each of the two weekly case conferences are attended by one of the psychiatrists and usually five or six other psychiatric professionals. I observed that the conferences usually revolve around the psychiatrist. For example, if the psychiatrist is not able to attend, the conference is cancelled, which is not the case if other staff members are absent. Discussions at the conference are led by the psychiatrist. If a disagreement arises regarding a patient, the psychiatrist will get the last word; however, the psychiatrists' opinions regarding patients are rarely challenged in the first place. The conferences tend to have a casual atmosphere and are often humourous, as staff members share stories about interactions or conversations with patients.

Pre-Board Conference As discussed in Chapter Three, every individual found Not Criminally Responsible must appear before the Board of Review at least once per year until they are granted an absolute discharge. The meeting is held at the inpatient facility, meaning that individuals discharged to the community must travel to the hospital to attend the meeting. This annual review is attended by the individual found NCR, psychiatric professionals from both the inpatient and outpatient facilities, a defence lawyer hired by the patient, a Crown Prosecutor and any other interested parties (e.g., family of the patient). Before granting a disposition, the Board of Review members interview the individual found NCR, and query the psychiatric professionals regarding the patient. The Board is also provided a written report regarding the individual prepared by the treating psychiatrist in collaboration with the psychiatric team.

Once a month, a *Pre*-Board conference is held at the outpatient clinic. This conference occurs approximately four weeks prior to the patient's annual Board of Review meeting. All patients who have an upcoming Board of Review meeting are requested to attend the Pre-Board conference. Usually, several individual cases are discussed in a single conference. Pre-Board conferences held at the outpatient facility are attended by the Forensic Psychiatric Clinical Director, the treating psychiatrist, all other psychiatric professionals who work on the NCR teams, and the individual found Not Criminally Responsible.

The Pre-Board conference is designed to allow all staff members to provide input into the written report that is submitted to the Board of Review. The conference focuses on all aspects of the patient including their behaviour, attitude, and compliance with treatment across the previous 12 months (i.e., since the individual's last Board of Review meeting). The ultimate goals of the Pre-Board conference are, first, to identify any potential dangers that the individual might pose to self or others; second, assess the probability and factors that increase the risk of these dangers; and third, develop recommendations regarding these dangers and risks for the Board of Review.

The Pre-Board conference begins with all NCR team members, but without the patient, in attendance. The treating psychiatrist provides a detailed review of the individual's circumstances either by reading aloud sections of the patient's file or from memory. This review includes information about: index offence, psychiatric history, medical history, criminal history, family history, drug/alcohol history, employment history, current living situation, progression through Board of Review system, and current warrant conditions. Occasionally, other staff members add details to this review. At the conclusion of the review, the psychiatric professionals often discuss one or two troublesome qualities of the patient, for example: resistance to medication, denial of mental illness, or pursuing what staff believe are unrealistic goals.

Once the review is completed, the patient is brought into the room and seated in a chair that is part of the circle of chairs in the conference room. Approximately eight to ten psychiatric professionals are also present. The individual is often seated next to the treating psychiatrist who proceeds to ask the patient a series of questions. Questions are often phrased, “Tell Dr. (Clinical Director)…” and can cover any topic, but usually eventually focus on the troublesome qualities previously identified by the psychiatric team. When the treating psychiatrist is finished asking questions, she/he will ask if anyone else has any questions. Usually only the Clinical Director will ask more questions. When the patient has responded to all the questions he/she is dismissed from the room.

The psychiatric professionals then discuss the individual’s presentation, demeanour and responses during the conference. Next, the treating psychiatrist asks each staff member what should be recommended to the Board of Review. Sometimes there is debate about what conditions to recommend, but consensus is usually reached quite quickly. A report summarizing the patient’s progress since the last Board meeting and any concerns or recommendations is subsequently prepared by the treating psychiatrist and sent to the Board of Review for the upcoming annual meeting. The entire process (excluding the drafting of the report) takes approximately 30 minutes for each individual case.

Pre-Board conferences are more formal and serious meetings than the case conferences. Conversation among psychiatric professionals tends to be more decorous and considered. On occasion, the treating psychiatrist and the Clinical Director debate the diagnosis, prognosis, or treatment of a patient. Rarely do other staff members participate in these debates or challenge the opinions of the psychiatrists.

The discussion between psychiatric professionals in the Pre-Board conference often involves careful consideration as to what information should be included in the report provided to the Board of Review. The report is often strategically constructed in relation to what the psychiatric professionals think that the Board of Review members will want to know or in relation to what the defence lawyer is likely to argue.

Individual Care Plan Meetings One of the two NCR treatment teams initiate meetings intended to provide therapeutic direction and goals for both the treatment team and the individual found Not Criminally Responsible. The Individual Care Plan (ICP) meeting is, in essence, an agreement or informal contract between the individual found NCR and the psychiatric treatment team. These two parties work together to construct a treatment plan that outlines the goals and expectations that both the patient and treatment team agree to carry out in the upcoming year. The meeting is attended by the members of the treatment team, the patient, and any other concerned individuals (e.g., family members, group home workers, etc.). Most patients managed by the treatment team will undergo an annual ICP meeting.

If the goal of the case conference is to ensure familiarity with the patient's *current* circumstances, and the goal of the Pre-Board conference is to review the progress of the patient across the *past* year, the goal of the Individual Care Plan meeting is to focus attention on the course of treatment for the foreseeable *future*.

The format of the ICP meeting is similar to the Pre-Board conference, however the proceedings are much less formal. The meeting begins with only the psychiatric professionals in attendance. The staff members review the case, most often by reading aloud reports contained on the patient's file. Unlike the Pre-Board conferences, during this initial phase of the ICP meeting the large whiteboard in the conference room is often utilised. While the reports are read aloud, a staff member stands at the whiteboard and creates a timeline that notes the patient's significant life events (e.g., criminal charges, psychiatric admissions, divorces, etc.). In addition, a genealogical chart or family tree is often created that links the patient with family members who have significant characteristics, such as mental illnesses, criminal records, alcohol abuse, and the like.

At this stage, risk assessment instruments may also be reviewed or completed by the treatment team. If it is the type of risk assessment instrument that was completed by the patient, the results of the instrument are reviewed and discussed by the staff members. Other risk assessment tools require the psychiatric professional to complete an inventory of questions. This type of instrument is completed collaboratively by the treatment team at the ICP meeting and the results are discussed. At the end of this review period, the treatment team provides some summarising remarks about the individual and discusses what they believe would be realistic treatment goals in the upcoming year.

The whiteboard is then cleared and the individual is brought into the conference room. After some general conversation with the patient (e.g. daily routine, medications, etc.), the team follows one of two approaches. One approach is to pursue a direct agenda of questions that require the patient to list specific goals or actions to be undertaken (e.g., What do you need to do to stay out of hospital?; What kinds of things can you do to prevent getting very ill?; What kinds of things do you do for stress relief?).

The second approach is more subtle. The psychiatrist begins this approach by asking the individual to list his/her goals for the upcoming year. Each goal is recorded in a column on the left side of the whiteboard. Staff members also occasionally suggest goals for the patient to consider. Next, the psychiatrist asks the individual to describe (potentially with help from staff) what obstacles exist that would prevent the achievement of these goals. This list is then recorded in a column in the middle of the whiteboard. Finally, the psychiatrist asks each staff member, including himself, to state what specific support the staff member can provide that would assist the patient in reaching the goals and avoiding the obstacles that have been established. This final list is recorded on the right side of the whiteboard. At the conclusion of this process, the psychiatrist summarizes what has been accomplished and reiterates what specific actions have been agreed to be undertaken by both the patient and staff members. The psychiatrist asks the patient if he/she agrees with what has been established. There is some opportunity for the individual to negotiate the action plan that was put into place through this process, but few take this opportunity. This portion of the meeting concludes and the patient is dismissed from the room.

The psychiatric professionals then take a few minutes to informally talk about how the meeting went, their impressions of the patient, his/her goals, presentation, demeanour, and so on. Notes taken during the meeting that reproduce the three columns on the whiteboard are subsequently typed out and placed in the patient's file. The entire ICP meeting takes approximately 60 to 90 minutes for each individual.

Family Therapy Sessions Some individuals found Not Criminally Responsible attend psychotherapy sessions with their family members (typically parents). Often these family therapy sessions engage a specific therapeutic technique called 'reflecting teams'. With this technique, the lead therapist, the patient and the family members engage in a therapy session in one of the small group therapy rooms on the ninth floor. While the session is in progress, other staff members observe the session from another room behind one-way glass. After a period of time (e.g., 30-40 minutes), the two groups change positions – the lead therapist, the patient and the family members observe from behind the one-way glass while the staff members reflect on or discuss details of the therapy session that they have just observed. When the staff members are finished discussing the therapy session, once again the two groups change positions and the patient, family members and lead therapist discuss their reactions to the suggestions of the other staff members. Family therapy sessions are commonly scheduled every few months for each family. The therapy session takes approximately 60 minutes.

Informal Encounters Informal encounters within the outpatient clinic also provide the opportunity to observe interactions between research participants. These informal interactions between participants occur in the reception area, occupational/recreational therapy room, hallways, coffee room, staff room, elevator, outside the building, etc.

Data Collection Methods and Data Analysis

Data Collection The basic method of data collection for this research project involved compiling fieldnotes gathered during the interactions between research participants described above. I endeavoured to situate myself as unobtrusively as possible and transcribe conversations and observe interactions between participants.

For example, during the data collection period of this study, especially on Monday and Tuesday afternoons, I waited either in the reception area or in the hallway outside staff offices for opportunities to sit in on clinical appointments. Before observing an appointment, I asked both the patient and staff member if it was appropriate for me to do so. If both participants agreed, I sat in an extra chair in the staff member's office and transcribed the conversation as accurately as possible. In the meetings or conferences, I joined the participants in the circle of chairs in the centre of the conference room and transcribed the conversation that took place.

When observing interactions, I did not participate in any of the discussions between participants, and if I was asked a question directly, I provided only the most minimal response. On a daily basis, I transcribed the fieldnotes into a qualitative data analysis software program (Atlas-ti version 5.2). This software program provided the means to store and organize the raw data. Within this software program I also maintained a research journal where I recorded observations, thoughts, and reflections of the data collection process, as well as preliminary interpretations of the data.

In total, over approximately a four month period, I observed 24 clinical appointments, 14 case conferences, 14 Pre-Board conferences, five Individual Care Plan meetings, and two family therapy sessions. The data presented in the chapters below are representative of these data collection events.

Data Analysis Preliminary data analysis occurred simultaneously with data collection. Through an inductive process, I moved back and forth from the data to emerging interpretations and back to the data. In this fashion, several patterns, themes, and categories emerged. At the conclusion of the data collection phase of the study, I embarked on a thorough analysis of the data. The first step was to break down the transcribed fieldnotes into small units that could be labelled with one or more themes. Some of these data units are observations or short exchanges between participants that consist of only a few words or sentences. Other data units are sections of longer conversations that consist of several sentences. This initial step in the analysis produced 461 data units. The next step was to attach initial themes to all these data units. In total, I identified 33 different themes in the data (e.g., mental illness, risk prediction, medications, resistance, identity, side-effects, etc.). For example, the following data unit took place in a Pre-Board conference:

> Psychiatrist: How difficult is it to stay off drugs?
> Sam: I always say no to drugs. I've been off for 20 months. I get asked to buy drugs in front of the building all the time.

I coded this data unit with the following themes: "inquiry→disclosure", "risk factor" and "self-reflection". Altogether, I applied 1259 themes across all data units.

During and following this initial coding stage, I developed themes, sub-themes and preliminary interpretations of the data. Again, through an inductive process of moving back and forth between the data, themes, preliminary interpretations and literature, several broad themes and sub-themes became apparent. As represented by chapters below, four broad themes emerged from the analysis: surveillance, risk, resistance, and ethics.

Ethical Considerations

This research project was approved by the Arts/Science/Law Research Ethics Board at the University of Alberta. In addition, the Research Coordination Committee at Alberta Hospital Edmonton approved the project on the condition that "identifiable health information" would not be gathered. Accordingly, I did not record diagnoses, detailed mental health issues or the specific nature of psychiatric symptoms. All data collected are depicted in this document in a manner that assures anonymity. Specifically, none of the names used are the actual names of participants and potentially identifying details were altered.

To obtain consent from individuals found NCR, I approached the patients directly and asked if they were willing to allow me to observe their interactions with the psychiatric professionals. If the patient provided initial verbal agreement, I escorted him/her to my office to complete the consent forms. Before completing the consent forms, I informed the patient of the purpose and nature of the research and the potential benefits and harm of participation. Individuals were assured that participation in this research project was voluntary, that they could decline or withdraw participation at any time, and that all information gathered would remain anonymous and confidential. Participants were also informed that the research was not intended to have any direct clinical benefits, that information gathered would not be shared with anyone else including clinical staff, and that no identifying information such as name or personal details would be made public. The individual then signed a consent form indicating that they understood the purpose of the study, the implications of their participation, and that all information gathered would be kept anonymous and confidential.

At the beginning of the data collection period, I approached as many potential participants as possible. After approximately two dozen patients agreed to participate, I concentrated on observing multiple interactions involving these individuals rather than adding new participants to the study.

The process of obtaining informed consent from patients may raise the complex issue of the extent to which individuals with mental health difficulties are capable of understanding or entering into agreements. Of course, all people have different capabilities; however, being found Not Criminally Responsible is *not* synonymous with cognitive difficulties/impairment or even current mental illness. Instead, it means that a court ruled that a mental disorder rendered the individual incapable of forming criminal intent at the time of the crime. That mental disorder, however – especially for individuals discharged to the community – may now be considered ‘under control’ or ‘in remission’. In other words, being found Not Criminally Responsible is a legal ruling, but it does not mean that the person is not capable or cannot enter into social or legal agreements. Therefore, a person found NCR can rent a home, vote, obtain credit from a bank, make a will, or decide to enter into any other legal or social contract that he or she wishes.

To obtain consent from the psychiatric professionals, I attended a staff meeting where I described the purpose and nature of the research and the potential benefits and harm of participation. Staff members were also assured that participation was voluntary, that they could decline or withdraw participation at any time, and that all information gathered would remain anonymous and confidential. In addition, they were assured that this research project was not an evaluation of the NCR program at FACS. All psychiatric professionals who deal with individuals found NCR in the clinic consented to participate.

All data collected for this project are closely protected. Note pads containing raw data are stored in a locked filing cabinet and the data analysis software package is stored on a computer that is password protected. Besides myself, no other person has access to, or has seen, the raw data.

Refle(x)ions

It is always important for a researcher to reflect on his/her understandings and place in the research process. Perhaps this is even more important in my case. As mentioned above, at the time of data collection, I was an employee of Forensic Assessment and Community Services, the research site. However, my responsibilities within this clinic did not include direct involvement with the NCR treatment program or individuals found Not Criminally Responsible. Obviously, members of the NCR treatment team knew me, and some of the patient-participants probably recognised me as a staff member of FACS. However, this familiarity did not appear to have a significant effect on the research process. Staff-participants were very accommodating to requests to observe them doing their jobs and on several occasions they ensured that I was invited to meetings or conferences. Likewise, patient-participants were also willing to allow me to be privy to private conversations and therapy sessions with psychiatric professionals. Generally, my presence was met with acceptance or indifference from patients.

Certainly, there were advantages and disadvantages in my role as researcher within this setting. A definite advantage was my familiarity and ready access to this research site. I was able to begin this research with the advantage of an understanding of the setting and a pre-established relationship with many of the participants. Nonetheless, the first task I undertook when I entered the setting as a researcher was to move beyond the familiar and gain an intricate and detailed understanding of all the procedures and processes involved from both the legal and psychiatric perspectives involving individuals found Not Criminally Responsible.

Conversely, a potential difficulty in this research was that I may have been biased or had selective perception toward certain aspects of the research context because of my familiarity with the setting. I seriously considered this matter, and one issue I identified early in the research process was what should be considered ‘data’ for this project. As I noted in my research journal, specific patient details (i.e., psychiatric symptoms, diagnoses, criminal histories, offence details, and the like) were *not* of interest. Of course, these kinds of details are the focus of the psychiatric professionals, as well as my focus as an employee of this setting.

However, as a researcher into governance, my focus shifted to considering *how* these details were presented, used, discussed, debated, negotiated, dismissed, and so forth. I reminded myself of this task by placing a 'post-it' note on my computer monitor which read "Think Sociologically!". Nevertheless, observations that I made and the particular data that I include in this document are inevitably selective. They should be considered within the contingencies of my own knowledge-production efforts. Thus, I do not claim, nor was I attempting, to produce a definitive truth.

A disadvantage of participant observation is that some participants may interact differently in the presence of an observer. In order to counter this possibility, I reassured all staff-participants that my presence was not for the purposes of evaluation, but rather to learn more about the processes of regulating criminal insanity and experiences of being Not Criminally Responsible. I often described my research interests to staff members as "the care and control of criminal insanity". At first, one or two staff members appeared apprehensive about my presence, especially in clinical appointments. However, after reiterating the specific goals of my research and, in one case, showing the staff member the contents of the fieldnotes taken from the clinical appointment, all staff-participants appeared comfortable (or at least not uncomfortable) with my presence.

While recognising that it was not entirely possible, I specifically requested that staff members refrain from altering their procedures or interactions with patients for my benefit. For example, at the beginning of one clinical appointment, in the presence of the patient, a staff member provided me with a brief history of the individual. This would not have occurred had I not been present. At the conclusion of the appointment, I informed the staff member that the historical background was not necessary to my research, and in fact I did not want her to alter her clinical procedures for my benefit. This appeared to be the only example of an interaction or procedure significantly altered because of my presence.

Similarly, at a Pre-Board conference, one staff member made a controversial statement, turned towards me, smiled, and said "We should watch what we say because we have an observer". However, she ignored her own advice and continued the discussion. Inevitably, an observer impacts the proceedings. However, being very familiar with procedures and how staff conduct themselves in this setting, I am confident that interactions and conversations were not dramatically altered as a result of my presence.

From the patient's perspective, it is a common occurrence to have someone (e.g., students, interns, residents) sit-in on clinical appointments or conferences. The perception I received from all the patient-participants was that I was perceived as just another person/student sitting-in and observing their appointment or conference with the staff. In summary, I was able to collect data in a manner that was as unobtrusive and non-disruptive as possible.

The next four chapters present the empirical results of the research project. Specifically, Chapter Five discusses governing criminal insanity through forms of surveillance; Chapter Six explores the confluence of risk, dangerousness and criminal insanity, illustrating how risk is assessed and managed in relation to these individuals; Chapter Seven describes how persons found NCR attempt to resist these forms of governance; and finally Chapter Eight examines how these individuals are encouraged to self govern and the techniques through which this process occurs.

Chapter Five – Surveillance

To be governed within liberal societies, one must be known. To be known, one must be visible in some way. Surveillance is the act of making phenomena visible. It involves the routine collection, processing and use of data in the administration, management and/or governance of those entities under scrutiny (Gilliom 2001; Lyon 2001). However, the goal of surveillance is not necessarily to simply see what is, but rather to render visible that which is desirable to see. Therefore, surveillance helps construct particular entities or problems by making them visible. The aims of making entities or problems visible are diverse: profit, organization, security, control, to name a few.

This chapter analyses the surveillance of criminal insanity. It explores the governmental techniques used to make the criminally insane visible, accentuating how surveillance in the community setting utilises both liberal and advanced liberal techniques – sometimes embedded within the same practices. Within the forensic psychiatric outpatient clinic, surveillance no longer relies on practices that require the subject to be held in a specialized space and watched (or at least led to believe they are being watched) at all times. Instead, surveillance diversifies, bringing under scrutiny not just behaviour but also a vast array of corporal and social elements, such as bodily functions, relationships, thoughts and emotions. In addition, surveillance in the community is no longer the sole responsibility of the psychiatric professional, but is dispersed across a wide range of individuals including family, friends, employers and neighbours. The result is that a more diverse collection of elements come under observation. Most significantly, individuals found NCR who are discharged to the community must become involved in monitoring themselves. This self surveillance requires a demonstration of 'insight', or the ability to identify, examine and articulate one's own thoughts, emotions and behaviours in a manner consistent with psychiatric knowledge.

Ultimately, these practices do not demonstrate a clear shift in governmental tactics, but rather a continuum, which sees surveillance tactics incorporating both liberal and advanced liberal elements. In particular, the hierarchical forms of disciplinary surveillance are supplemented with practices that could be described as 'rhizomatic' (Haggerty and Ericson 2000). These latter forms of surveillance rely on many individuals, including the subject of surveillance him or herself, to gather diverse forms of information which is assembled together by psychiatric professionals to aid in regulating the individual.

The first section of this chapter provides a theoretical discussion of this shift in surveillance practices. It then turns to an examination of the surveillance practices in the forensic psychiatric outpatient clinic, which includes a detailed discussion and analysis of self surveillance. The chapter concludes by considering the implications of surveillance practices in making criminal insanity visible.

Criminal Insanity and Visibility

Compared to other forensic or criminal populations, individuals found Not Criminally Responsible often face more intense forms and degrees of surveillance. This scrutiny may often seem out of proportion when compared either to the severity of the crime committed, or to the forms of control faced by individuals found guilty of similar offences. As discussed in Chapter Two, over the last century and a half, surveillance of criminal insanity has almost exclusively been facilitated through forms of psychiatric intervention. Once found criminally insane, individuals come under the care of psychiatric professionals whose interventions strive to make criminal insanity visible and thus governable. These interventions range from the continuous surveillance that characterises inpatient confinement on a locked forensic unit at a psychiatric hospital, to practices utilised by forensic outpatient clinics that encourage the patient to engage in self surveillance and continually disclose behaviours and thoughts.

In both the inpatient and outpatient settings, individuals found criminally insane are dealt with on the assumption that they present a potential danger, either to themselves or others. This is an example of Boyne's (2000) suggestion that the activities of surveillance operate under the heading of danger. The concept of dangerousness is rather loosely defined, but refers to individuals whose behaviours are thought to endanger the rest of the population to a degree that extraordinary measures are deemed necessary to control them (P[illegible]tt 1997, 1999). The potential danger that the criminally insane are thought to embody is identified and regulated through surveillance. The consequence is that a 'dangerous' identity is constructed through surveillance practices. In short, individuals whose actions are thought to be irrational, unpredictable and ungovernable are deemed to represent a danger which, in turn, requires surveillance.

Boyne (2000:290) proposes that two categories of individuals in particular have an intimate and intricate link to danger and surveillance: criminals and the vulnerable. By definition, those found criminally insane embody both of these categories. Their criminal behaviour constitutes a danger which requires surveillance in order to protect others, while their mental illness necessitates the need to be watched over and cared for. Both their potential for criminal behaviour and their illness require monitoring. In fact, the two are intertwined: an exacerbation of the illness may lead to criminal behaviours, just as their criminal behaviours may be indicative of a mental disorder. Surveillance becomes the front line in the defence against the dangers posed by the criminally insane. Psychiatric professionals attempt to make known the dangers thought inherent within an individual found criminally insane in order to predict, neutralize, govern, care for, cure, and/or regulate the individual. Through various techniques of surveillance, psychiatric professions insert the criminally insane in a field of visibility which judges them, evaluates them on a normative framework and submits them to forms of regulation. The remainder of this chapter delineates the techniques by which this is accomplished.

Shifting Practices in the Surveillance of Criminal Insanity

Throughout their tenure in the medico-legal system, individuals found NCR face many different forms of surveillance. From the time they are found Not Criminally Responsible, nearly all individuals are detained in a locked ward in a psychiatric hospital. Within this setting, these individuals face familiar, well recognized forms of surveillance. Doctors and nurses make regular rounds, checking patients for signs of dangerousness and/or mental illness. A multitude of daily regimes and activities, such as diet, medications, therapy, leisure and recreation, are closely regimented, scheduled and monitored. Architecturally, the forensic psychiatric inpatient units are designed to permit the staff to easily conduct visual surveillance of patients. For example, at Alberta Hospital, the nursing office is located at the centre of the ward with all the individual housing units arranged around it in a semi-circle. All leisure or recreation areas of the ward are located to allow staff to view all activities in those areas. Even the curtains over the windows on the door of the individual units are hung on the outside of the door, rather than the inside of the door, so that staff may pull them aside to observe activities inside the unit at any time. All of this is augmented by closed-circuit cameras located throughout the building, with all movement and activity monitored by security personnel.

These techniques of regulation and surveillance are common to most total institutions. Foucault (1977) describes these tactics as exemplars of disciplinary forms of power relations. Through this organization of space, time and bodies, a disciplinary order is created that facilitates the visibility of the subject, the control of the body and the production of knowledge.

Specifically, Foucault (1977:170-194) discusses how subjects are ‘individualized’ through three disciplinary techniques: hierarchical observation, normalizing judgement and the examination. Briefly, the goal of hierarchical observation is to link visibility with power. It allows the ‘disciplinary masters’ to oversee individuals with a single gaze, thus providing an efficient instrument of regulation. Normalizing judgement involves establishing acceptable behaviours and standards to be achieved by individuals. Examination is the combination of the previous two techniques whereby individuals are made visible and classified by a 'normalizing gaze'. The examination brings individuals into a field of visibility where their qualities are collected, documented, and classified resulting in the individual becoming a 'case' which is then compared to the norm.

Disciplinary experts, such as psychiatrists and psychologists, have established particular rules of judgement and standards for measuring and comparing persons (e.g., the DSM[1]). Individuals under the disciplinary gaze are evaluated against and subsequently encouraged to regulate or conform their own behaviours in order to meet these standards. When a patient is examined, it encourages them to engage in a process of active self-formulation. As a result of this process, the individual may accept the identity imposed on him/her, or, as discussed in Chapter Seven, may resist this subjugation and seek to forge an alternative identity.

Another important disciplinary mode of governance is panoptic surveillance. Foucault describes the Panopticon, Jeremy Bentham's late 18th century architectural prison design, as a "cruel, ingenious cage" (1977:205). Briefly, Bentham's design proposed a compound where a central guard tower was to be encircled by a structure that contained windows both facing the tower and opposite the tower. This arrangement would allow light to flow through the housing units and make all individuals and activities inside the units visible to those in the central tower. The lighting in the central tower would be designed to prevent individuals on the outer perimeter from knowing whether they were being observed, or even if anyone was in the tower. While this architectural arrangement allows many individuals to be watched by very few observers, the ultimate aim was for inmates to come to control themselves because they would never be sure they were being observed and must adjust their behaviour as if they were being watched at all times. Therefore, the inmate "is seen, but he does not see; he is the object of information, never a subject in communication" (Foucault 1977:200).

The Panopticon is more than just an architectural design. For Foucault, it exemplifies specific relations of power that emerge in disciplinary institutions such as the factory, hospital, prison, or family. Power relations within these institutions are arranged, through a comparable organization of space and time, to provide 'the overseer' the opportunity to directly watch 'the observed'. Therefore, surveillance in these settings works as a component of power relations and is both an instrument and expression of power. In short, disciplinary modes of governance attempt to place subjects in a field visibility, compare their behaviour to an established norm, which, ideally, encourages individuals to modify their actions to meet these standards.

Following the publication of Foucault's *Discipline and Punish,* the Panopticon has been the central metaphor used by surveillance studies. While it serves as a vivid example of the functioning of disciplinary power, the Panopticon should not be taken as the only way in which the 'problem of visibility' functions. Several commentators (e.g. Bauman 1992, Boyne 2000, Haggerty 2006, Lianos 2003) suggest that the Panopticon, as a paradigm for contemporary surveillance, is an overextended metaphor and has limited relevance in an increasing number of contexts. In other words, panoptic surveillance, with its reliance on disciplinary institutions and methods, may no longer be applicable in settings where power is exercised in different ways.

For example, within the psychiatric inpatient setting, visibility is conferred by the institution. The structure of the institution (i.e., the practices and architecture) dictates how surveillance will occur. However, as outlined in the provisions enacted by Bill C-30, most individuals found NCR will eventually be discharged to the community. Despite the absence of the more institutional structures, surveillance of individuals discharged to the community does not diminish but simply changes form and tactics.

The surveillance of patients attending a forensic psychiatric outpatient clinic is accomplished through many different means. Most explicit are the clinical appointments where patients must present themselves to a clinical staff member. As described in the previous chapter, other practices, such as psychotherapy sessions/groups, Individual Care Plan meetings, Pre-Board conferences, and occupational/recreational therapy programs also provide opportunities for staff to scrutinize the patient's actions, beliefs, and desires. Therefore, disciplinary tactics certainly remain relevant in the outpatient setting, but, new techniques, such as expecting the patient to engage in self surveillance (discussed in detail below), are not only encouraged, but become a necessary component in the regulation of these individuals.

In the community, the surveillance of the criminally insane entails a hybrid of liberal and advanced liberal techniques. Here, clinical practices can be thought of as part of a 'surveillant assemblage'. The notion of surveillance as an assemblage of techniques provides a useful heuristic device to help understand how individuals are made visible. According to Haggerty and Ericson (2000:608, 611), a surveillant assemblage is a visualizing practice that brings together "a multiplicity of heterogeneous objects, whose unity comes solely from the fact that these items function together, that they 'work' together as a functional entity". The surveillant assemblage breaks down the subject into a series of discrete signifying 'flows'. These flows can be comprised of an unlimited assortment of observable phenomena such as bodies, behaviours, chemicals, knowledge, and so forth. The assemblage acts as an information gathering and organizing device, converting a spectrum of information into knowable form. The flows that are part of this process exist prior to any particular assemblage, but are organized and fixed into temporal and spatial dimensions by the assemblage. Metaphorically, rather than the 'central tower' of the Panopticon or Orwell's all-seeing-eye, an assemblage is 'rhizomatic' (Deleuze and Guattari 1987) – a decentralised, malleable set of processes. In this experience, "surveillance is 'designed in' to the flows of everyday existence" (Rose 1999a:234) rather than being a specialized function carried out within a hierarchical power structure. Therefore, "the surveillant assemblage is not a single physical entity or system, but the sum total of the surveillance capacity that can be trained on a location or population. As such, it is less a 'thing' than it is a potentiality that can be actualized to varying degrees depending on what and how observational regimes are combined and aligned" (Haggerty and Gazso 2005:173).

Certain features distinguish disciplinary surveillance (as an exemplar liberal techniques of governance) from the surveillant assemblage (as indicative of advanced liberal tactics). For example, panoptic surveillance is mainly concerned with conduct and thus does not focus on elements that are not visible to the eye. In contrast, the surveillant assemblage is comprised of features that are both visible and invisible to the human eye. This means that a number of information gathering devices other than the eyes are necessary to make criminal insanity visible. For example, in this setting, other human senses, such as smell, and complex technological equipment that renders information contained within the urine, blood, brain impulses and chromosomes of patients are utilised.

Unlike panoptic surveillance, the surveillant assemblage does not specifically rely on the organization of time, space and/or architectural design to facilitate surveillance. While the surveillance of individuals found NCR discharged to the community often occurs at the psychiatric outpatient clinic, the 'collection' of information can occur through many forms and in many locations, including the patient's own private residence. In addition, unlike panoptic surveillance where only the 'disciplinary master' or overseer monitors the subject, within the surveillant assemblage many individuals (e.g., friends, family, community members, etc.) may become involved in the surveillance of subjects. Significantly, in the surveillant assemblage the patient must become active in their own surveillance and communicate the findings to the clinical staff. Unlike panoptic surveillance where the subject is seen, but does not see, and is the object of information but not the subject in communication (Foucault 1977:200), within the surveillant assemblage the subject must both see and communicate relevant information to the psychiatric professionals. This ability not only provides 'raw data' to the psychiatric staff, but also is a means to demonstrate responsibility.

In short, rather than the binary outcome of panoptic surveillance (i.e., the observed is either exhibiting behaviour that is within the expected limits or outside the expected limits), the surveillant assemblage is 'rhizomatic' (i.e., surveillance utilises several different methods, encompasses many different elements, happens in various locations, and involves numerous individuals).

Surveillance in Practice Within the Forensic Outpatient Clinic

This section details how the surveillant assemblage operates in the outpatient setting. It outlines the different flows of information that are gathered, how this information is assembled and utilised, and the diversity of individuals responsible for collecting this information. The section concludes with a detailed discussion of possibly the most important element of the surveillant assemblage, the practice of self surveillance that individuals found NCR must undertake when discharged to the community.

Within the forensic psychiatric outpatient setting, clinical practices serve as the potentiality for the surveillance of the individual. These techniques entail a hybrid of liberal and advanced liberal governmental practices. For example, the examination is still a routine and important technique of surveillance, but now provides functions beyond the 'normalizing gaze'. In particular, this technique is used to facilitate practices that enlist patients in their own surveillance.

Through clinical practices the subject is visualized by breaking it down into different flows. These can be divided into two broad informational flows, corporal and social. The 'corporal flow' can range from the presence or absence of the body itself to 'bodily' features such as blood, urine, or characteristics of the individual's chromosomes. The 'social flow' can include factors such as the individual's social presentation, or social interactions related to virtually any aspect of the individual's life such as employment, accommodation, family or friends. The following table provides examples of specific elements that come under surveillance within the forensic psychiatric outpatient clinic. The corporal and social flows are discussed in more detail below.

Table 2. Elements Under Surveillance

Corporal Flows	Social Flows
• Body	• Presentation of Self
• Appearance	• Medical Regime
• Body Odour	• Medical Concerns
• Hygiene	• Symptoms of Mental Illness
• Weight	• Employment
• Urine	• Accommodation
• Blood	• Financial Concerns
• Blood Glucose	• Relationships
• Neurological Impulses	
• Chromosomes	

Corporal Flows

Several ubiquitous conditions are placed on individuals found NCR who are discharged to the community. Among these conditions is the requirement to attend a psychiatric outpatient clinic on a regular (e.g., weekly) basis. This condition enables the most obvious form of surveillance utilised by the psychiatric staff. Attending the clinic brings the individual into a hierarchically ordered space of visibility which permits staff to examine the corporal individual. This surveillance occurs at several levels. First of all, the individual found NCR literally has to show up at the clinic to be visible. Simply fulfilling this condition indicates to staff a basic level of compliance and accountability. At the weekly appointment, each individual is seen by a staff member. This one-on-one meeting provides the opportunity for staff to observe other corporal features of the individual, such as appearance, personal hygiene, cleanliness, weight, mood and attire. As a clinical staff member observed about one patient: "As soon as he becomes smelly, dirty and rude we know there's trouble". This comment demonstrates that a wide range of corporal features can be utilised as indicators of mental illness. Here, rather atypical forms of governmental 'data', such as body odour, personal appearance and demeanour, are judged as possible signals of deteriorating mental health and/or potential dangerousness.

Women found NCR are held to higher standards of personal hygiene and appearance by psychiatric professionals. During case conferences, staff are more likely to comment on the attire, appearance, cleanliness and/or personal hygiene of women than men. For example, at one case conference, it was noted that a female patient came to her appointment with a coffee stain on her blouse. Men found NCR have to reach extreme levels of uncleanliness before staff make similar comments.

Other aspects of bodily comportment are also observed. Facilitated by the condition that they must abstain from alcohol or illicit drugs, many individuals found NCR are required to provide urine samples used to determine if they have consumed any illicit substances. Those patients who have a history of alcohol or drug abuse and/or those who the treatment team suspects are currently abusing these substances must provide a urine sample at the clinic, which must be witnessed by a staff member. The samples must be provided as frequently as once per week and usually occur at random times of the week. Therefore, individuals must conform their behaviours outside the clinic as the collection of urine samples is used to make the patient's past behaviours visible and thus known to staff members.

Urine samples are occasionally collected for more strategic purposes. For example, at one case conference, the clinical team expressed concern regarding a patient who had purchased a new cell phone and new designer label clothes. The consensus was that the individual may be dealing (and probably using) illicit drugs. The psychiatrist requested that a nurse collect a urine sample from the individual at the group home where the patient resides, rather than at the clinic during his usual weekly appointment. Staff members debated at length about what day of the week to carry out this task. The team surmises that patients expect to give urine samples on a Monday or Tuesday, the day when most attend the clinic. Consequently, staff believe that those patients who are inclined to consume drugs do so on specific days of the week so that it will be less likely to be detected on a Monday or a Tuesday. The team concluded that if they obtained urine samples on a Thursday they would be more likely to detect any illicit drug use. The staff also decided to obtain urine samples from several patients at the group home so as not to raise suspicion in the one particular patient they were explicitly targeting. In other words, other patients had their urine screened simply because a different patient was under suspicion. One staff member rationalised this strategy by commenting: “It’s nice if we could remind them that we are here to help them not do drugs”. Therefore, collecting urine samples not only provides a method of surveillance that makes certain physiological features visible, it is also connected with other practices of governance exploited by clinical staff. In this case, collecting urine samples is used to remind patients of the staff’s ability to conduct surveillance for alcohol or illicit drugs and thus detect behaviour that occurs outside of the staff’s immediate visual purview.

Many individuals found Not Criminally Responsible also have their blood monitored. Clozapine, an anti-psychotic medication often prescribed to psychiatric patients, has an iatrogenic effect. If prescribed at incorrect dosages, the medication destroys the patient’s white blood cells which then compromises the immune system and leads to infections. Therefore, use of this medication is heavily monitored. First, only psychiatrists registered with the manufacturer of the medication are allowed to prescribe the drug. Second, all patients who receive the medication must also be registered with the drug manufacturer. On a regular basis (e.g., once a week), patients must provide a blood sample at the clinic which is sent to a local laboratory. The laboratory sends the results back to the clinic and a staff member at the clinic must enter the results into a computer provided by the drug manufacturer. The results are then forwarded, through the internet, to the drug company. Accompanying the laboratory results are also basic demographic information regarding the patient (e.g., age, gender, etc). The drug manufacturer compiles the results in a database and if an individual's white blood cells reach an unacceptable level, an alert is sent from the drug manufacturer to the prescribing psychiatrist. Thus, within the surveillant assemblage the regime of governance itself has to be monitored. Here, elements of the 'corporal flow' become multi-layered, where a sample of blood makes visible both features of the patient and practices of the psychiatrist.

Clozapine also has the side effect of inducing weight gain. As a result, weight gain is used as an indicator that the patient is taking the medication and, conversely, loss of weight or lack of weight gain is taken as an indication that the patient might not be taking the medication. Consequently, patients are regularly weighed and their weight is recorded and monitored for any changes. As one clinical staff member commented about a patient who has a history of not taking prescribed medications: "He's put on weight again – which is a good sign he's back on the Clozapine". Here, the corporal form serves as an indicator of compliance with psychiatric intervention. Direct monitoring of the patient is not necessary, as corporal features speak to patient behaviour.

Most diabetic patients' blood glucose levels are also monitored. Patients are provided with a small blood glucose meter which reads strips that contain a drop of the patient's blood. When the strip is placed in the meter, the meter displays information regarding the patient's blood glucose level. In addition, the meter stores the information gathered from the strip. On a regular basis (e.g., once a month) a clinic nurse downloads the information stored on the meter to a computer where a detailed history of the patient's blood glucose levels is displayed. The information gathered through this process reflects the patient's nutritional and dietary habits and, by extension, the ability or willingness of the patient to manage their diabetic condition. Extended periods of poor dietary habits results in increased surveillance of not only blood glucose levels, but also of the patient's general behaviour and demeanour, as poor management of a diabetic condition is seen by clinical staff as a possible indication of deteriorating mental health.

The body, blood and urine of individuals found Not Criminally Responsible are the most common corporal features that are monitored. However, on occasion, other corporal features are also made visible. For example, electroencephalograms (EEG) are performed which monitor electrical activity in the brain. Also, genetic testing is conducted to visualize the patient's chromosomal characteristics. These tests are carried out in an attempt to further understand the nature of the person's psychiatric illness. Psychiatric expertise is required to interpret these features. For instance, an EEG reveals neurological activity patterns that can be interpreted as indicative of many different psychiatric disorders, such as: depression, attention deficit, anxiety, learning disabilities, or sleep disorder, to name a few. Revealing a disorder, through the combination of corporal surveillance and psychiatric expertise, leads to treatment modalities that attempt to ameliorate the conditions through drug and/or psychological therapy.

By focusing on various corporal features of the patient, staff members render assorted problems visible and thus governable. In the psychiatric outpatient clinic, both external and internal corporal features, as widely ranging as body weight, body odour and brain activity, come under surveillance. This configuration of surveillance practices is not exactly panoptic in nature, but rather can be described as an assemblage in that they incorporate a wider range of elements than panoptic surveillance.

In sum, in the outpatient setting, clinical practices retain some familiar disciplinary functions, but also incorporate some novel advanced liberal functions. Patients are still examined and judged according to normative standards. In addition, clinical practices also facilitate a process where the corporal body is broken down into different flows and a wide assortment of problems are made visible and in need of regulation. What becomes a target of surveillance is often coordinated with the governmental objectives of staff members. In other words, that which needs to be governed comes under surveillance and that which comes under surveillance becomes governed. As more and new corporal features become visible and thus known, the possibilities for governance multiply. This governance may facilitate a diagnosis, a treatment strategy or assorted other forms of regulating an individual's behaviour or interaction.

Social Flows

When a patient attends the forensic psychiatric outpatient clinic this also provides the opportunity for 'social flows' to be monitored. Social flows are those aspects that concern an individual's social presentation or interaction with other individuals. At a basic social level, attending the clinic provides the opportunity to monitor the patient's social demeanour. This can occur both directly and on closed-circuit television (CCTV) from the time the patient enters the main doors of the office building and rides the elevator to the 8th floor, to the time he or she leaves the building. The security guard posted on the main floor can both see the person as they enter the building and observe the person through CCTV cameras mounted in the elevator. If the security guard believes that an individual's actions are untoward, the guard will follow him/her to the clinic and notify a staff member. Once on the 8th floor, the patient must sign in at the reception desk and wait in the waiting room for the next available staff member.

The receptionist has a clear view of the entire waiting room both directly and through rounded mirrors strategically placed in corners of the room. In addition, the waiting room and public areas of the clinic (i.e., entrance, hallways, stairways) are monitored through CCTV. Again, any untoward behaviour is brought to the attention of a clinical staff member. On occasion, patients make themselves more visible in order to achieve certain goals. For example, they can cause a disturbance or be a nuisance in the waiting room which results in the receptionist notifying a clinician and asking that the individual be seen on an expedited basis. Patients who are less troublesome (i.e., make themselves less visible) rarely enjoy such prompt attention.

The usual procedure for a clinical appointment involves a staff member going to the waiting room and calling the next patient from the sign-in list. The patient is then escorted from the waiting room through a locked door into the inner office area and to the staff member's private office. Once there, the staff member engages the patient in a conversation that generally follows a question-answer format. This conversation serves as a form of examination and a method of surveillance where the individual found NCR is expected to reveal him or herself according to certain normative standards. The psychiatric professional pays close attention to all aspects of how the patient presents him or herself. First and foremost, the presentation of self is observed for signs of mental illness and/or dangerousness. The clarity, consistency, and credibility of the presentation is scrutinized as well as the content of what is presented. Therefore, the clinical interview is both a form of social interaction as well as a technique of making social flows visible.

Most clinical appointments cover similar substantive components. Almost all clinical interviews include discussion regarding three broad topics. The first are medical concerns, for example: the medications the patient is receiving, the side effects of the medication, and potential symptoms of mental illness. The following is a typical exchange between a clinical staff member and a patient.

> Nurse: How are you?
> Larry: I had a hallucination a while ago (describes hallucination).
> Nurse: When?
> Larry: About 10 days ago.
> Nurse: Was it true? Do you believe it?
> Larry: No, I've had years of experience with it.
> Nurse: What did you do?
> Larry: Ignore it.
> Nurse: Good. Are you taking your meds crushed or whole?
> Larry: Whole.
> Nurse: And you are taking them?
> Larry : Yes.
> Nurse: With orange juice?
> Larry : Water.

The staff member later indicated that this patient has a history of 'cheeking' his medications (i.e., placing the pill in his mouth but not swallowing it and then spitting the pill out when no one is looking). Therefore, until recently, the group home where the patient lives was crushing the medications, putting it into a teaspoon of jam and making sure the patient swallowed the jam (it is hard to 'cheek' jam). This interaction provides a typical example of the surveillance of therapeutic processes. This particular interaction also illustrates the surveillance of the patient's specific behaviour with respect to his medical issues as well as the surveillance of the medical regime itself and its effectiveness. The staff member closely observes the patient's social presentation during the interview and the individual is expected to articulate concerns and issues regarding medications. Therefore, by visualizing medical issues, staff are able to monitor and govern the patient's psychiatric condition.

The second broad topic dealt with in clinical interviews are everyday living matters, for example: employment, accommodation, and financial matters. This exchange between a nurse and a patient recently discharged to the community provides an example:

> Nurse: How is everything?
> Tina: Good. I'm going to school.
> Nurse: What are you taking?
> Tina: English 33.
> Nurse: What will you do after?
> Tina: Go to college.
> Nurse: And take what?
> Tina: A trade or maybe nursing.
> Nurse: Nursing? How are your marks?
> Tina: 55 - 65.
> Nurse: Well, you have to have really good grades to get into nursing. Let's just take this one step at a time. First, get your high school diploma.

In this example, the staff member is making visible not only the patient's current daily activities, but also future plans and the likelihood or credibility of those plans. In making everyday living matters visible, staff attempt to identify potential troublesome issues or situations emerging in the patient's life, and also position the patient's activities on a normative framework. If the patient's day-to-day activities are judged to be irresponsible, extravagant or hazardous, staff members will consider this a potential sign of deteriorating mental health and encourage the individual to correct the social transgression. If the patient refuses or is not able to rectify the situation, staff consider this a definite sign of mental illness and work to remedy the situation (e.g., re-admittance to inpatient facility). Therefore, patients must engage in everyday living matters that meet the approval of psychiatric professionals.

The final broad area of discussion concerns significant persons in the patient's life, for example: partners, family, friends, and roommates. In the following example, a psychiatrist, while making visible the social connections of the patient, is attempting to discern if the patient is experiencing social difficulties that might exacerbate a mental condition.

> Dr: Do you socialize at all?
> Peter: I call my uncle, I call my sister in (name of country). But I lost all my friends…
> Dr: …When you went through all this? (Being found NCR)
> Peter: I also lost some friends when I quit drinking years ago.
> Dr: Do you meet anyone face to face?
> Peter: My uncle, and I go to (place of worship) once in a while. Some people there don't want to talk to me. They talk about me.
> Dr: Do you get lonely?
> Peter: I got used to it.

The patient's direct social interactions with other individuals are used as a barometer of mental health. Individuals who cannot successfully negotiate social interactions may be considered to pose a danger to others. In this situation, staff closely monitor the individual's interactions or may even mediate between individuals in order to assure a desirable outcome. The persons with whom the individual found NCR is associating are also monitored. Patients are encouraged to interact with certain individuals and discouraged from associating with others.

Throughout the period of time that the staff member and patient are in contact, the staff member is alert for any signs of mental illness. Mental illness is thought to be manifested in disorganised or unusual answers provided by the patient, or in sudden or unusual changes in social interactions or life circumstances. Staff members take note of both the specific details of the patient's answers as well as how information is presented. Through this method, the clinical interview serves as a technique to visualise potentially troublesome social situations. However, the clinical interview is not a neutral technique of surveillance for detecting problematic situations; it may also be used to construct or reinforce problems or entities that require psychiatric intervention. The following is an excerpt between a staff member and a patient who is considered by staff to be very noncompliant, not likely to continue to take prescribed medications, likely to take illicit drugs if granted absolute discharge, and possibly a danger to others if not supervised and medicated. On the other hand, the patient states that he eschews street drugs, poses no danger to others, should be granted an absolute discharge and believes that he is over-medicated.

> Jack: I have trouble with my brain.
> Psychiatrist: What kind of trouble do you have?
> Jack: Memory. I can't remember things.
> Psychiatrist: Do the meds help?
> Jack: I got to take them, that's all.
> Psychiatrist: So they don't help?

> Jack: I was smarter before I took them.
> Psychiatrist: Smarter?
> Jack: There is a difference. There was one week I was crazy (and committed a NCR index offence), but I was smarter (then).
> Psychiatrist: What happens when you are crazy?
> Jack: I stabbed someone in the eye.
> Psychiatrist: Has there been other times when you were crazy?
> Jack: No.

In this interaction, the staff member initially tries to ascertain the legitimacy of the patient's complaint regarding his memory. The staff member dismisses this concern and explores the patient's compliance with medications. When the patient displays some resistance to the need for medications, the staff member establishes, through the patient's own words, the danger the patient poses when he is mentally ill and, by implication, the need for medications and continued supervision. The patient resists this categorisation by claiming that the index offence was an isolated event. However, the staff at the clinic would strongly dispute that claim. This example demonstrates how psychiatric professionals use the examination to construct and monitor problems. Through the social interaction of the clinical interview, the staff member discerns the patient's current mental state as well as past social interactions, and this establishes the need for continued surveillance and supervision.

The above examples illustrate how the clinical appointment makes social flows visible. Information on how the individual presents him or herself and on other social interactions is gathered either directly through observing and interacting with the patient or indirectly by having the patient give an account of social flows that occur outside the clinic. In this process of making social flows visible, both staff and patients are involved in constructing certain entities and problems. On one hand, psychiatric professionals attempt to make visible certain entities and problems, while, on the other hand, individuals found NCR may strive to present the social flows of their life in alternative manners. The interaction between the staff member and the patient may result in agreement, capitulation or resistance to what is made visible.

At the conclusion of the clinical appointment, the staff member will make a few notes regarding the appointment that are subsequently placed on the patient's file. These clinical notes provide a running narrative of both the corporal and social flows of the patient. They serve to create a 'case' that documents the staff member's assessment of the general mental health of the patient and may be used to track potentially troublesome situations which require staff intervention.

The subsequent use of the information that is gathered during the clinical appointment is pragmatic in the sense that it is reassembled and scrutinized in the hope of developing strategies of regulation and/or treatment which can be applied against the case. The practical transformation of information into strategies occurs at 'centres of calculation' where the surveillant assemblage functions as a mechanism to capture and stabilize information flows.

Centres of Calculation

Centres of calculation are locations, such as laboratories, police stations, insurance bureaus, statistical institutions, and the like, that do not deal with the corporal body, but rather with the 'data double' that is created through the surveillant assemblage (Haggerty and Ericson 2000). While the data doubles "refer back to particular individuals, they surpass a purely representational idiom.

Rather than being accurate or inaccurate portrayals of real individuals, they are a form of pragmatics: differentiated according to how useful they are in allowing institutions to make discriminations among populations" (*ibid*:614). Therefore, at the 'centre of calculation', the data double serves as the marker toward which institutional practices are directed and against which they are evaluated. In short, flows of information are gathered, processed, compared and marked with distinguishing indicators prompting certain institutional actions.

In the forensic psychiatric outpatient setting, clinical practices function as the devices or procedures for capturing information. Once the information is gathered, the weekly case conference functions as the centre of calculation where the discrete signifying flows are brought together and reassembled for institutional purposes.

At the weekly case conference, as each person's name is read from a list, staff members contribute information concerning that individual. For example, one nurse might report that the patient has gained weight; another nurse will check the file for the latest blood level counts; the social worker will describe the state of the individual's apartment from the last home visit; the occupational therapist will describe his interpersonal manner with other patients during a program; the psychologist will report the results of a risk assessment tool; and the psychiatrist will comment on issues that were discussed in therapy. Thus, each signifying flow is transformed into information. This information breaks up the unique corporal individual into discrete bits of information that are then reassembled into an increasingly elaborate data double. Certain information might prompt further action. Plans are discussed and implemented at the case conference. These decisions might include increased surveillance (e.g., ordering drug tests; planning home visits; re-admission to hospital), a change in therapy tactics (e.g., involving family members in therapy; change in medication), or if the treatment team feels that the individual is doing well in the community, a recommendation to the Board of Review that an absolute discharge be considered.

The following situation occurred in a case conference when staff uncovered a problematic event regarding a patient. The discussion begins when the person's name is read from the list of NCR patients and the nurse who had last seen the individual reports that he was complaining of side effects from the prescribed medication. The nurse also reports that the patient admits to having started smoking after having quit for a lengthy period of time. She recounts their conversation about the exact nature of the side effects and the resulting discomfort the patient is experiencing. The nurse also reports questioning him about the amount of tobacco being smoked, why he began smoking again, and also reports asking questions about other vices often engaged in by the individual. She states that while the patient admits to smoking a great deal, he denies drinking alcohol or gambling. At this point, the recreation therapist mentions that the patient has recently been absent from scheduled recreation events. It is noted that he does not usually miss these outings. The patient's file is retrieved and the psychiatrist examines the amount and types of medication that he is receiving. The psychiatrist decides that a change in the prescription might be warranted. However, first, the psychiatrist schedules an appointment with the patient in order to further explore the cause of the side effects and discuss the possible change in medication. The discussion then turns to the possible reasons why the patient is currently experiencing medication side effects and why he has also taken up smoking. After several hypotheses are discussed, the team comes to the consensus that it is financial troubles that are causing problems. The social worker adds that the individual has borrowed a significant amount of money from a family member. It is noted how in the past, when a similar situation had occurred, the patient experienced a relapse in mental illness. It is agreed that all staff members should be extra vigilant around the individual and that contact with him should be increased. Consequently, in addition to the appointment scheduled with the psychiatrist, the occupational therapist agrees to meet with the patient to discuss financial concerns and budgeting techniques, the nurse agrees to pay him a visit at his home, and the social worker agrees to call the family member to discuss the situation.

This vignette illustrates how at the case conference particular flows of information are collected and assembled, and how decisions and actions regarding patients emerge out of this process. By making various elements of the individual visible, staff members assemble a plausible explanation and a course of action. However, the ambiguity of results creates a space for considerable discretion. At the next case conference, it is possible that the various elements under surveillance might be re-assembled in a manner that results in a different course of action.

Agents of the Assemblage

As Foucault (1977:184) describes, the examination establishes over an individual a visibility which allows the overseer to differentiate and judge. Put simply, the clinical interview provides the opportunity to make the subject visible according to a host of axes. Consequently, in the surveillance of individuals found NCR who are discharged to the community, the psychiatric professional certainly maintains the central role as the 'overseer' of the criminally insane. However, the outpatient clinic is not the sole site, nor is the psychiatric professional the sole agent that carries out the surveillance of criminal insanity.

Psychiatric professionals often recruit, either directly or indirectly, other individuals for the surveillance of the individuals found Not Criminally Responsible. For example, spouses, family members, roommates, friends, group home workers, or even other patients are employed in the surveillance of individuals found NCR. This surveillance may take the form of staff members soliciting information from these individuals or advising these individuals to be vigilant of certain issues and report back to the staff member. For example, family members will often be informed if a patient has missed or refused a dose of medication, or group home workers will be notified regarding a change in medication. These individuals are asked to "keep an eye on" the patient and report any unusual behaviour back to the psychiatric professionals, which they frequently do. Likewise, patients often inform staff members about what other patients say, what they do, who they meet, what they eat, where they go, how long they sleep, how much they smoke, and so on. While, due to privacy regulations, staff members rarely solicit this information from patients, they readily accept it.

The incorporation of 'non-professional' individuals in the surveillance of the criminally insane complements the fragmentary character of the surveillance assemblage. 'Data' concerning patients are collected through many different sources and may take many different formats. These disparate fragments of data are assembled through clinical practices into flows of information. These flows of information are then filtered through the case conference which translates information about the patient into institutional action.

However, one very significant individual has thus far not been accounted for in the surveillance of the criminally insane. This is the patient him or herself. Quite possibly the primary mechanism through which surveillance of criminal insanity in the community occurs is through self disclosure. This is a process where individuals observe their own thoughts, emotions and behaviours and report them to others. This ongoing practice is a form of self surveillance that has its foundation in disciplinary surveillance, but introduces new elements into the process.

Self Surveillance

As discussed above, surveillance practices reflect relations of power. As such, surveillance in the forensic psychiatric outpatient setting takes on a different form than surveillance in the inpatient setting. Within disciplinary institutions (e.g., the factory, the prison, the hospital, the family) the organization of space and time facilitates surveillance practices. In these settings, surveillance often entails a centralized, top-down process where those lower on the social hierarchy (e.g., the worker, the inmate, the patient, the child) are situated under the gaze of those higher on the hierarchy (e.g., the supervisor, the guard, the physician, the parent). (Sur)veillance, after all, means to keep watch from above.

However, within the forensic psychiatric outpatient setting, different relations of power prompt different surveillance techniques. For example, the outpatient setting does not have the full benefit of a space amenable to codification in which observation can be organized and standardized. While patients must attend regular appointments at the clinic, the vast majority of their lives are lived outside of the direct view of the psychiatric professionals. In addition, staff at the outpatient clinic have a reduced ability to directly organize all of the time of individuals living in the community. Again, while many patients attend programs at the clinic, most of their time is spent away from the setting. In short, without the institutional practices to confer visibility, practices of surveillance in the community must shift accordingly. For example, obtaining urine samples from patients or soliciting information from family and friends provides psychiatric professionals the ability to 'observe' behaviours that occur outside of their purview.

Possibly the most significant addition to surveillance practices in the community is that patients become more directly involved in making themselves visible. In other words, self surveillance becomes a mode through which individuals are visualized. However, the practices of self surveillance that are utilised in the outpatient setting must be distinguished from the subjectification that results through panoptic forms of surveillance predominant in the inpatient setting. A primary distinction is that panoptic surveillance places the subject in a passive position, with a focus on the behaviour of the individual, while the practices of self surveillance place the subject in a more active position where the focus is on internal factors such as emotions, attitudes, and beliefs as well as behaviour.

Foucault's discussion of panoptic surveillance states that the "major effect" of the panopticon is "to induce in the inmate a state of conscious and permanent visibility that assures the automatic functioning of power" (Foucault 1977:201). With panoptic surveillance, power is rendered automatic by procuring self surveillance. "He who is subjected to a field of visibility, and who knows it, assumes responsibility for the constraints of power; he makes them play spontaneously upon himself; he inscribes in himself the power relation in which he simultaneously plays both roles; he becomes the principle of his own subjection" (Foucault 1977:202-203). In other words, the subject complies with power through forms of self monitoring. Norris and Armstrong (1999:6) characterise this self monitoring as "habituated anticipatory conformity". It is power that the subject internalises but not necessarily identifies with; power that is abided and obeyed, but whose values are not necessarily ascribed to (Vaz and Bruno 2003). Thus subjects, in this case the targets of panoptic surveillance, can be primarily seen as *passive* entities that internalise and act in relation to disciplinary forms of power.

This dystopic reading of Foucault's discussion of surveillance characterises power as purely repressive. However, Foucault also emphasises that power should be considered productive. Later in his career, Foucault's work concentrates on the ways in which subjects are involved in self formation (e.g., Foucault 1985:25-28). Here individuals are not just simply seen as internalising forms of power, but are also *active* in utilising power relations in the production of an ethical self (Chapter Eight will focus on this theme in detail). Thus, the subjects of surveillance can be thought of as active in self formation through practices of surveillance, especially self surveillance. For example, through surveillance by others, the patient's actions and thoughts are made visible and normalized. Here the individual is invited to adjust action, thoughts and perceptions of the self to fit into this normative grid. Likewise, through self surveillance, the subject is encouraged to fashion a self that identifies with governmental power. In this way, governmental power acts both directly on the subject through surveillance by others and indirectly on the subject through self surveillance.

However rather than viewing the subjects of surveillance as either passive or active entities, it might be more useful to consider a continuum. On one end of the continuum are panoptic techniques that place the object of surveillance in a passive position. Here, subjects of surveillance are watched and respond through a dystopic 'anticipatory conformity'. On the other end of the continuum are techniques of self surveillance that facilitate active self formation. Here, subjects of surveillance are to look upon themselves and respond in ways that develop an ethical self. This continuum combines Foucault's interest in surveillance as a form of visibility that assures the automatic functioning of power with his later interest in techniques that promote care of the self.

The governance of criminal insanity modulates somewhere between these two limits, incorporating elements from both ends of the surveillance continuum. Inpatient psychiatric facilities lean towards panoptic techniques, with less significant emphasis on active self surveillance. On the other hand, outpatient psychiatric practices utilise self surveillance to a much greater extent, and panoptic surveillance techniques become less salient.

Self Surveillance in Practice

Like the other tactics of surveillance discussed above, self surveillance is facilitated and revealed through clinical practices. Many interactions between staff and patients at the forensic outpatient clinic provide patients with the opportunity to disclose self surveillance practices. Within these interactions, individuals may voluntarily divulge information regarding self surveillance practices. However, more commonly, the questions that staff ask are invitations to reveal self surveillance practices. Virtually any question can invite self surveillance. For example, the simple question, "How are you?", is of course a very common conversation starter, but in this context it is also an invitation to reveal the findings of self surveillance.

Likewise, virtually any topic can be the subject of self surveillance. The issues considered through the practices of self surveillance can range from perceiving signs of mental illness to abstaining from street drugs to eating enough vegetables. However, no matter the issue, the function of self surveillance is to encourage active self formation. The topics monitored through self surveillance by individuals found NCR can be organized into several broad themes. These themes include ‘medications’, ‘mental illness/symptoms of illness’, ‘illegal drugs/alcohol’ and ‘lifestyle’. The following outlines these themes through two levels of self surveillance. The first level can be termed ‘self surveillance of external factors’, and the other level can be termed ‘self surveillance of internal factors’.

Self Surveillance of External Factors

In self surveillance of external factors, individuals found NCR discharged to the community are to note and reveal actions or behaviours that would be visible to staff members if the patient was constantly under immediate surveillance. Since the outpatient setting does not confer the same visibility as the inpatient setting, outpatients are expected to make visible factors that would be readily observable in an inpatient setting. For example, a staff member will pose questions to the patient around the theme of medications: “Are you taking the meds?”; “When do you take your meds?”; “How many meds are you taking?”. These questions would not be necessary in the inpatient setting as psychiatric staff control the administration of medication and have the opportunity to directly observe the effects. However, in the outpatient setting, the psychiatric professionals must rely on the patient to provide self surveillance regarding medications. The following discussion is a typical exchange regarding medications.

> Nurse: How's the meds working? Too much? Too little?
> Terry: I'm restless. I toss in bed – can't sleep.
> Nurse: How many (side effects medication) do you take?
> Terry: One a day.
> Nurse: Why don't you take two instead tonight.
> Terry: I don't like screwing with my meds.
> Nurse: Then how about taking it later in the evening – at 9:30. Try it tonight. Then phone me tomorrow.
> Nurse: Is your injection due today?
> Terry: No.

As this interchange demonstrates, patients must not only be responsible for taking the medications on their own, but also must take note, remember and report details surrounding the event. This type of self surveillance and presentation of self is a form of accountability. Patients must demonstrate the ability to recognize the effects of medications and identify any benefits or ill-effects. This entire process takes place outside of the purview of the psychiatric professional, who consequently must rely on the individual's self surveillance to provide details of the medical regimen.

Likewise, staff will ask questions about other issues that prompt patients to report on their self surveillance practices. For example, in the theme of illegal drugs/alcohol, individuals are often asked to report on their past and/or present drug or alcohol consumption. The following discussion occurred after a patient reported that she was going to spend the weekend at a local hotel with friends.

> Nurse: Who is staying at (name of hotel) with you?
> Helen: About 10 of us - (names about 3-4 names). I won't lie, there will be alcohol, but no drugs. My friend (name) won't let anyone do drugs.
> Nurse: How about you …
> Helen: (interrupts) No, I don't do drugs.
> Nurse: I mean, will you drink alcohol?
> Helen: No, I can't. It's on my warrant. I'd like to, but I can't.
> Nurse: Good.
> Helen: You can call me on my cell phone. I'll have it there.

In the outpatient setting, the patient cannot be monitored at all times, therefore individuals are expected to self monitor and abstain or prevent themselves from engaging in certain behaviours, even if the behaviour would be desirable to the individual. In the above interaction, the patient not only demonstrates self surveillance but also offers up a way that she could be surveilled more directly (i.e., through a cell phone).

More generally, individuals found NCR are asked questions about their lifestyle. Staff inquire about virtually any topic regarding the patient's lifestyle, for example: "How clean do you keep your place?"; "How's your diet, are you eating enough vegetables?"; "What do you do to keep busy all day?" and "What are you doing that would tell the Board that you are doing OK?". Again, patients must take note and report on aspects of their life that are not immediately visible to psychiatric staff. Questions about lifestyle are intended to not only monitor certain aspects of the patient's life, but also to encourage individuals to attend to these topics. In making these aspects visible, individuals found NCR must actively examine and consider the issue at hand. In this manner, a benefit of self surveillance is the opportunity for the individual found NCR to demonstrate rationality and responsibility, or conversely, to expose irrationality and irresponsibility.

Self Surveillance of Internal Factors

In self surveillance of internal factors, individuals found NCR are to consider and divulge 'internal states' (e.g., emotions, beliefs, thoughts) that are not visible to an outside observer. The general goal of this type of surveillance is to make visible the internal states of the individual and to encourage the patient to take notice of these states. However, the ultimate goal in the forensic outpatient setting with this type of surveillance is to ascertain if the individual has 'insight' into their situation. Insight is an elusive concept that, for present purposes, can be defined as seeing and understanding one's own internal state. As the word itself implies, (in)sight means having sight into an inner state – an inner eye. This type of surveillance is not simply the anticipatory conformity of panoptic self monitoring (i.e., conforming one's behaviour to a significant other's expectations), but rather the individual must produce and present evidence of the formation of a particular kind of self. For individuals found NCR, an 'insightful' person is one who has formed and is able to present to others evidence of a rational, reasonable, responsible self.

To reveal insight, the individual must demonstrate, first, the ability to 'see' one's own internal state, second, the ability to appreciate the significance of these internal states, and third, the willingness to communicate these findings. An individual who 'has insight' is able to see, appreciate and communicate internal states that are consistent with what significant others believe are accurate for that person. Simply 'saying all the right things' does not imply insight. For example, the following interaction occurred at a Pre-Board conference with the psychiatrist leading the questioning of a patient.

> Psychiatrist: How have you been doing over the last year?
> Len: Good. I had some crack cocaine 26 months ago, but I've been really good since then.
> Psychiatrist: How do you spend your day?
> Len: Playing X-Box in my room and coming here. I have no objections to the meds.

Psychiatrist: What do the meds do for you?
Len: Makes the symptoms go away.
Psychiatrist: What would happen if you stopped the meds?
Len: Seriously, I think I would be OK. I don't want to hurt anyone, violence scares me.
Psychiatrist: How difficult is it to stay off drugs?
Len: I always say no to drugs. I've been off for 20 months. I get asked to buy drugs in front of the building all the time. I've been on the warrant for 13 years. I'd stay off alcohol and drugs, come to FACS, stay out of trouble.
Psychiatrist: What would change if you got absolute discharge?
Len: I'd take my meds. I'd have more freedom. I'd pack up and move. (hesitates for a moment) What would change? Not very much.
[Meeting ends and patient leaves the room.]
Psychiatrist: He's saying all the right things, but he would fall apart in no time flat if off the warrant. Can't prove it, but we all know it.

In this case, the patient mostly provides all the 'correct' answers, and even anticipates some questions. He knows that the psychiatric professionals believe that he will stop taking medications if discharged from the warrant and are concerned about his past drug use. Therefore, he addresses these issues directly. However, there is consensus among the team members that this individual 'lacks insight' and has just learned to say what the team is expecting to hear. Interestingly, other patients could say the exact same words as 'Len', but be considered to 'have insight'.

Therefore, insight is more than the words spoken, it is demonstrated in the manner the patient presents his/her inner states and in how accurate the staff members believe this depiction to be. As the psychiatrist's comment "Can't prove it, but we all know it" demonstrates, insight is not tangible but it is somehow knowable. The individual must demonstrate insight by saying all the right things in a manner that convinces significant others that they are authentic. In other words, the possession of insight is the ability to practice self surveillance of internal factors in a manner that is consistent with the aims and objectives of those in authority and to present them in a convincing fashion.

As with all other forms of surveillance, this form of self surveillance or insight is facilitated through clinical practices. The standard procedure is for staff to ask questions of individuals found NCR that elicit evidence of insight. These questions may be general in nature (e.g., "Why are you NCR?" or "Tell us about yourself"), or may relate to one of the standard themes. For example, within the medication theme, staff may ask questions such as: "Why do you take meds?" or "What do the meds do for you? Do they have an effect?". In the following interaction, the psychiatrist presents an opportunity for a patient to disclose insight about taking medications.

> Psychiatrist: Do you think the meds help you?
> Sarah: I'm not sure about the (anti-psychotic), but the anti-depressants are OK. The last time I went off the anti-depressant, I ended up in the hospital. But I had no meds the whole time I was in the remand.

Likewise, within the theme of illness/symptoms, patients are frequently asked questions that attempt to make visible insight about their mental illness. Examples of these type of questions would be: "Can you tell us what you notice when you are getting sick?" and "What kinds of things can you do to prevent getting very ill?". The following excerpt is taken from an Individual Care Plan meeting where staff members questioned the patient.

> Staff: What do you need to do to stay out of hospital?
> Henry: Take my meds, stay busy, stay away from religion [part of this patient's mental disorder]. I think I have a good awareness of when I'm getting sick.
> Staff: Can you tell us what you notice when you are getting sick?
> Henry: I get a feeling of desperation; I get into bad habits like staying up all night and sleeping all day; and religion.

> Staff: Do you lose insight when you get sick?
> Henry: Yeah, I lose perspective.
> Staff: When you go psychotic, you don't think you're ill?
> Henry: I think I don't need meds. It's part of the religion. I think God will heal me. It's like I don't want to do it, (but) I'm compelled by God - my soul is on the line.
> Staff: You don't think you are ill then?
> Henry: Yeah, when it gets really bad.

Within the theme of drugs, patients are asked questions that seek to reveal the effects of drugs on the individual (e.g., "Do you get paranoid when you smoke joints?") or questions that seek to reveal the individual's moral stance on drug consumption (e.g. "Why should you give up drugs?"). In the following example, a staff member and a patient discuss the patient's long history with illicit drugs.

> Nurse: How come you quit the drugs?
> Alan: It's good to quit. Screwed up things.
> Nurse: It probably brought you here.
> Alan: For sure. I'm moving away from it. I feel better staying away from it. I'm a lot happier. I was always grumpy.
> I used to have a roommate a while ago who was always smoking up. I resisted for a while, but it was hard because the guy was smoking constantly. I eventually succumbed and got back into it.
> Nurse: Mmmm…
> Alan: I'm pretty sure I'll stay away from it. Almost sure. I have to make sure who I'm having a friendship with … be careful when I'm making friends.

Questions regarding medications, mental illness, or illicit drug/alcohol consumption could be seen as biased and leading in the sense that virtually all patients will "say the right things" in relation to these topics. However, it is not just the content of the answer that interests the psychiatric professional, but rather the ability to demonstrate insight or the self surveillance into internal states and the ability to appreciate and effectively convey these internal states that concerns the psychiatric professionals. Insight is how the results of self surveillance are presented and the level of agreement between what the patient divulges and what the psychiatric professionals expect to hear.

The 'possession' of insight is seen by clinical staff as an essential and necessary quality for individuals found NCR. Observations of this research setting show that individuals must demonstrate the ability to examine inner states and 'develop insight' before noteworthy milestones are achieved. For example, clinical staff must be convinced that a patient possesses significant levels of insight into their circumstances before additional privileges are recommended to the Board of Review. Therefore, through clinical practices and self surveillance techniques, psychiatric professionals and patients engage in a process of making visible inner thoughts, feelings, emotions, beliefs and attitudes, especially as they pertain to possible behaviour. Psychiatric professionals evaluate the insights of the patient against forms of knowledge and expertise and a determination is made of the veracity and accuracy of the insights, as well as the impact that these insights might have on future behaviour. To put it succinctly, to have insight is to have produced and presented a self that is consistent with particular governmental rationalities and techniques of those in authority. This 'insightful self' is an individual who is considered rational, predictable, governable, and by extension, not dangerous. The creation of an insightful self is perceived by staff as possibly one of the most important (and also possibly most ambiguous) tasks performed by patients at the forensic psychiatric outpatient clinic.

Surveillance Politics – What Is Being Visualized?

From their entry into the medico-legal system, individuals found criminally insane are made visible. Surveillance practices are both a reflection of macro level governmental power relations and a strategy by which power is exercised at the micro level.

For example, within the contemporary forensic psychiatric outpatient clinic, surveillance tactics are largely carried out through interpersonal interactions between psychiatric professionals and patients. Interactions between these individuals are a social performance where psychiatric professionals attempt to bring to light certain emotions, thoughts, and behaviours of patients which, in turn, become the particular targets of governance; whereas individuals found NCR attempt to portray a self that is rational and responsible which, from their perspective, hopefully leads to less severe forms of regulation and more freedoms. Therefore, these everyday interactions involve tactics where a 'self' is produced and performed based on the strategic goals of the interactants.

From a broader macro perspective, within liberal modes of power, practices of surveillance function to create a "docile body" (Foucault 1977:138) – that is, a body that has both increased capacities (e.g., is useful and efficient in economic terms) and, at the same time, diminished force (e.g., is obedient and compliant in political terms). Therefore, it is a 'docile body' that disciplinary surveillance attempts to make visible. Alternatively, within advanced liberal forms of power, surveillance activities strive to facilitate the formation of an 'ethical self' within individuals. The objective here is not so much to 'create' particular kinds of individuals, but to 'manipulate' their existing capacities. Therefore, within advanced liberal forms of power, what is being visualised are self-forming activities that are indicative of an ethical self. With this type of power relation, surveillance works to identify self governing behaviours that are considered to be insightful and responsible. This suggests a shift in the functionality of power. Specifically, liberal power relations carry out surveillance in order to create docile bodies, while advanced liberal power relations attempt to govern and manage individuals through facilitating and encouraging ethical self formation. As Gilliom (2001:128) suggests, "surveillance programs should not be viewed as mere techniques or tools for neutral observation. They are, rather, expressions of particular historical and cultural arrays of power – program goals, criteria, and data sources all express social, political and technological conditions of the times".

Discussion: From (Sur)veillance to (In)sight

In the 19th century, those found criminally insane were detained in penitentiaries where the primary goal was to remove these individuals from society. They were considered to be incapable of rational thought and subsequently deemed unpredictable and dangerous. Surveillance in this setting primarily involved ensuring that the body of the individual remained contained within the walls of the institution. The early 20th century found the criminally insane detained in psychiatric hospitals. Surveillance within this setting reflected disciplinary forms of power that monitor the individual through corporal, spatial, and temporal forms of surveillance. These practices sought to create an individual that engaged in self monitoring and came to control their own behaviour. Since the end of the 20th century, most individuals found Not Criminally Responsible can expect to be discharged to the community and come under the care and regulation of staff at a forensic psychiatric outpatient clinic. With this arrangement of power relations, surveillance takes a different form. Within this setting, the individual is made visible through flows of information which are gathered and assembled via clinical practices. A vital source of information are practices of self surveillance where individuals found NCR must scrutinize their own thoughts, beliefs, emotions and behaviours and disclose the findings to clinical staff. This process makes it possible to provide a constant surveillance of individuals found Not Criminally Responsible, but without psychiatric professionals actually having to physically contain or constantly watch the individual. Through this process, surveillance becomes an activity that is 'built in' to the everyday flow of life of the individual found NCR and thus does not require a specialized setting or equipment.

The differing forms of surveillance involving the criminally insane demonstrates how changing forms of power bring about new strategies and techniques of surveillance. These shifts in surveillance highlight several continuums upon which practices of visibility may be considered. The first, and most obvious, shift in the surveillance of criminal insanity is the change in physical setting in which the practices of surveillance take place. The discharge of the criminally insane from institutional (i.e. correctional or psychiatric) settings to the community prompts attempts to make visible not only the individual's behaviour outside of the clinic, but also additional domains of the individual's life, such as their social relationships and their insight into their circumstances. This shift in the setting of surveillance draws attention to other modifications in the surveillance of the criminally insane. For example, there is a shift from hierarchical or vertical forms of surveillance to horizontal or rhizomic forms of surveillance. The hierarchical observation of panoptic surveillance is transformed, if not replaced, with a strategy that assembles flows of fragmented information collected by or from a diverse range of sources. These sources of information may include psychiatric professionals, the patient, family and friends of the patient, or even non-human data collection devices such as CCTV cameras, and bio-medical devices. Additionally, one can note a shifting emphasis from forms of surveillance that place the subject in a passive position to forms of surveillance that place the subject in an active position. With the latter forms of surveillance, subjects do not passively internalise the effects of power relations but rather are actively involved in practices of self surveillance that contribute to the formation of an ethical self. These various shifts not only highlight changes in the strategies and techniques of surveillance of criminal insanity, but also in the politics of surveillance. Thus, surveillance of the criminally insane reflects broad, macro strategies of power and also interpersonal, micro strategies of power.

To conclude, surveillance represents an important technology in governing criminal insanity. The process of making both criminal insanity and sanity visible reflects and serves the functions of power. Within the last decades of the 20th century, shifting power relations have influenced not only how criminal insanity is made visible, but also what is made visible. Panoptic surveillance, with its hierarchical structure, is supplanted with rhizomic forms of surveillance that assemble fragments of information from diverse sources. Surveillance techniques that produce passive forms of subjectification are supplemented by techniques that encourage active forms of subjectification. The consequence is that the object of surveillance shifts from a compliant, docile self to a responsible, insightful self.

Chapter Six – Risk

Life is pregnant with risks: floods, crashing stock markets, crime, to name just a few. However, despite the real consequences of these phenomena, risk itself is not a tangible entity. Rather, risk is a way to assess and categorize the relationship we have to elements in our environment. Something becomes a risk only after we make an assessment of that entity and deduce that it presents a hazard. Therefore, the river is not a risk, but our assessment of the rising waters in relation to our homes leads to an awareness of a risk; the stock market is not a risk, but our assessment of market conditions in relation to our financial portfolio creates an awareness of a risk; and an individual is not a risk, but our assessment of the individual's behaviour in relation to our notions of security produces an awareness of a risk. As Garland (2003:52) notes, "something becomes a 'risk' only to the extent that its potential for adverse consequences has been brought to notice and subjected to some kind of estimation". In other words, nothing is a risk until it is identified and pronounced as a risk.

From a lay perspective, criminal insanity is synonymous with dangerousness and risk. To the general public, individuals deemed criminally insane exhibit behaviours that are potentially threatening and thus require constant monitoring or exclusion from society. Indeed, through the Board of Review system, individuals found Not Criminally Responsible are confined to an inpatient psychiatric facility because they are deemed to pose a significant threat to society. They are discharged to the community only when these threats are seen to be reduced and are considered to be manageable through a forensic psychiatric outpatient clinic. Individuals found NCR are granted an absolute discharge only when the Board of Review determines that the risks they pose to themselves or to society are minimal and may be managed by the individual without the intervention of the psychiatric system. In short, from both the lay perspective and the legal position, risk is an important factor in governing criminal insanity. However, when exploring the governance of criminal insanity through risk, it is important to recognize that there is no such thing as 'a risk' without the attempt to govern that risk. That is, risk does not exist before the attempt to govern it. Therefore, the risks posed by the criminally insane are not fixed or stable, but rather undergo a continuous process of assessment, management and transformation.

This chapter analyses how individuals found Not Criminally Responsible are governed through discourses of dangerousness and risk with a focus on the practices of risk assessment and management in the forensic psychiatric outpatient setting. Here, risk assessment and management are integral strategies for governing criminal insanity. Compared to the inpatient setting, risk assessment and management within the outpatient setting takes on a different quality. In brief, the focus of risk assessment and management within the inpatient unit involves acquiring types of knowledge that facilitate the diagnosis and treatment of psychiatric illnesses that place the individual at risk of relapse. In other words, what are the risks *to* the individual found NCR. The focus of risk assessment and management in the outpatient clinic shifts to acquiring types of knowledge that facilitate the prediction of individual behaviour, specifically behaviour *of* the individual found NCR that presents a risk to self or others. The management of psychiatric illnesses remains a concern of psychiatric professionals in the outpatient setting, but a vast array of other phenomena, such as behaviours, thoughts, emotions, attitudes, relationships, and so on, come under surveillance in order to assess the degree to which they influence the risk posed by the individual.

This research project finds that the prediction of individual behaviour entails an assortment of techniques and practices. Most notable, within the outpatient clinic, risk assessment involves a blend of clinical and actuarial techniques. Clinical techniques utilize the 'subjective' expertise of psychiatric professionals to assess risk, while actuarial techniques involve the completion of 'objective' risk assessment instruments. Risk assessment practices may encompass both of these techniques depending on the individual in question and the psychiatric professional conducting the assessment.

Likewise, risk management practices in the inpatient and outpatient settings take on different strategies. Risk management within the inpatient facility is fairly straightforward. Those assessed as 'risky' are simply detained in a secure forensic unit where their interactions with others are closely regulated and monitored. Within the outpatient setting, risk management techniques must encompass a wider variety of strategies. These risk management strategies involve formal practices such as the administration of psychiatric medications or patient-professional interactions such as the annual Pre-Board Conference. Other less formal risk management techniques include involving non-professional individuals, such as family members or group home workers, to assist in the management of risk factors presented by the individual found NCR. However, possibly the most significant difference between the inpatient and outpatient setting involves requiring the individual found NCR to be responsible for managing their own risk factors. In short, individuals found NCR discharged to the community must demonstrate the ability to assess factors that pose risks, as well as manage these factors in a way that decreases the likelihood of relapse or re-offence.

The rationalities and techniques of risk assessment and management in the outpatient settings should not be seen in binary opposition to the rationalities and practices in the inpatient setting. The differences or shifts in practices between these settings are not a simple or smooth transition. Rather, the outpatient setting incorporates a hybrid of rationalities and practises revolving around risk depending on the individual in question and the preference of the psychiatric professional.

This chapter discusses the rationalities and techniques of risk assessment and management in the outpatient setting. It is divided into three main sections. The first explores the concepts of ambiguity, uncertainty and liminality. Specifically, it explores how situations of uncertainty or ambiguity instigate assessments of risk. That is, risk always exists in contexts where outcomes are ambiguous or uncertain. This section also discusses the outpatient clinic as a liminal setting. Passage through this state, either forward toward absolute discharge or back to the inpatient facility, depends on the level of risk the individual is thought to pose.

The second section explores the interplay of criminal insanity, risk and danger. Danger is defined as the potential for harm that inheres in a person or a situation, whereas risk is a measure of that potential. While an individual found Not Criminally Responsible may possess the potential to do harm, risk is the measure of the probability or likelihood of that potential. Over the last couple of decades, several commentators have noted a contemporary shift in strategies that determine and regulate danger (see Castel 1991; Cohen 1985; Feeley and Simon 1992). As noted by the commentators, there is a shift from an individualized, reform-based treatment of the subject to a formalized, rationalized categorization of subjects into risk levels utilizing actuarial techniques. In other words, a shift from liberal to advanced liberal rationalities and techniques. I note a similar shift in the contemporary governance of criminal insanity from practices that attempt to manage dangerousness through treatment to practices that attempt to govern risk through prediction. While not denying the actuality or importance of this shift, this research problematises these changes by suggesting that it is more complicated, erratic, and inconsistent than the literature would suggest.

The final section of this chapter illustrates how risk is assessed and managed in a forensic psychiatric outpatient setting. This section conveys the multifaceted nature of governing criminal insanity through rationalisations of risk. Specifically, the section discusses: 1) the procedures through which risk is considered and communicated in this setting; 2) how psychiatric professionals assess risk; and 3) the various techniques by which risk is managed in the outpatient clinic.

Ambiguity, Uncertainty and Liminality

If modernity entails the use of reason and rationality with the goal of achieving order and control, then insanity presents a conundrum for modern sensibilities. Acts that are conducted with reason and rationality can be placed on a continuum. At one end are acts considered good, right, just, fair, and so on; at the other end are acts considered evil, selfish, wrong, immoral, and the like. While we may not always agree with the behaviours or where they should be placed on this continuum, we understand these behaviours and can make sense of them. Conversely, an insane act is behaviour that we cannot allocate to any point on the continuum. An insane act is behaviour that stands outside of our attempts to categorize and order. It is not that an insane act opposes 'good' or 'evil'. Rather, an insane act is outside of reason; it is simply "unreason". The following discussion takes up this idea of categorisation and order and considers how acts deemed insane relate to notions of ambiguity, uncertainty and liminality.

In his discussion about ambivalence and modernity, Zygmunt Bauman (1991) discusses our striving for order and our discomfort with situations that do not fit into our understandings of order. He considers the "other of order" as those entities that do not fit into any category or definition. "The other of order is the miasma of the indeterminate and unpredictable. The other is the uncertainty, that source and archetype of all fear. The tropes of 'the other of order' are: undefinability, incoherence, incongruity, incompatibility, illogicality, irrationality, ambiguity, confusion, undecidability, ambivalence" (Bauman 1991:7). These terms can all be used to characterize criminal insanity.

An individual found Not Criminally Responsible fits such characterizations because of the ambiguity surrounding the meaning of acts considered insane. As discussed in Chapter Two, the individual deemed NCR has been found by a court of law to have committed a criminal offence, however, the person's mental state at the time of the incident is thought to have rendered him/her incapable of appreciating the act or of knowing that it was wrong. Thus the individual committed a crime, but without criminal intent. The person is neither guilty nor innocent. The actions of a criminally insane defy our desire to impose a clear categorisation. This ambiguity fosters uncertainty and a feeling of unease towards a person found Not Criminally Responsible.

Feelings of uncertainty and unease drive attempts to resolve ambiguity through strategies that manage the "other" and affix the individual to a category. The first and most effective manner of dealing with ambiguity is to simply remove or exclude the entity that is causing the difficulty. Ideally, this removes the threat that the ambiguous entity represents. Another method for dealing with ambiguity is to limit or prescribe contact with the "other". However, limited contact does not necessarily remove the danger that the "other" possesses. Therefore, vigilance must be exercised to identify, assess, manage, and immobilize the dangerous qualities that the ambiguous "other" possesses.

Attempts to manage the ambiguity of acts deemed criminally insane have followed both of the above strategies. However, whether the exclusion of the criminally insane took the form of detention in a prison or in an asylum, the result was virtually the same – the individual, and the ambiguity he/she represented, was isolated from society.

More recently, the dispositions granted to individuals found Not Criminally Responsible have changed, and can now range from detention in a hospital, to discharge to the community, to absolute discharge. Detention, despite refinements in psychiatric practice and the conditions of institutions, has basically the same result today as it did in the 19th century – exclusion. At the other extreme, the disposition of absolute discharge was not even possible until Bill C-30 was passed in the Canadian Parliament in 1992. However, here I would like to focus on the middle disposition – discharge to the community. Within this context, individuals found NCR are set again in an ambiguous state. They are not excluded from society through confinement in a psychiatric hospital, but neither are they completely free from legal and psychiatric regulation. In essence, they are ambiguous individuals in an ambiguous situation with an ambiguous fate. Consequently, community forensic psychiatry, especially with the care and regulation of the criminally insane, represents a liminal state.

An individual found Not Criminally Responsible is discharged to the community when it is deemed that he/she no longer presents an imminent threat, but still requires surveillance, regulation and discipline. Concomitant with a discharge to the community is the condition of regular attendance at a forensic psychiatric outpatient clinic. Such individuals are not considered to be imminently dangerous, but yet not free of significant risks. They are cared for and supervised in a setting that is less limiting than an inpatient setting, but more limiting than receiving an absolute discharge. Therefore, in this setting, the job of the forensic psychiatrist is to constantly evaluate, classify and manage an ambiguous risk, with the goal of moving the person out of this liminal state, either toward the freedoms of absolute discharge, or back to detention in the inpatient facility. In essence, psychiatrists are experts in clarifying ambiguity by assessing the risks of uncertain situations and ambiguous individuals.

Risk assessments are, therefore, undertaken when decisions must be made in the context of uncertainties.[1] If a situation produces a certain outcome, there is no risk involved – the outcome is known. However, uncertain outcomes present the opportunity for risk to be calculated. The responsibilities of both the Board of Review and the psychiatric professionals involve making decisions based on such outcomes. For example, at least once a year the Board of Review of each province must meet with each person found Not Criminally Responsible and decide whether to relax, intensify or maintain the legal conditions imposed upon the individual. As will be discussed below, this process involves consideration of inherently uncertain phenomena, that is, the future behaviour of persons found NCR. Given the Board of Review's mandate to protect society and the rights of the individual found NCR, Board members must weigh uncertainties and assess risks. As established in case law in *Winko v. British Columbia (Forensic Psychiatric Institute),* the Board of Review engages in a "risk-management exercise" which allows that "uncertainties with respect to the extent to the threat posed by the accused be resolved in favour of the safety of the public" (p. 632).

Uncertainty and risk play differing roles in the inpatient and outpatient psychiatric facilities. Individuals detained within the inpatient setting experience a more limited range of possible actions, as compared to individuals discharged to an outpatient setting. Within the inpatient facility, the physical design of the locked forensic unit restricts an individual's free movement. In addition, they are subjected to a highly structured daily routine. Therefore, the potential actions of inpatients fall within a narrower range. In contrast, individuals discharged to the community do not face the same degree of structural or disciplinary restrictions on their conduct. This translates to a greater range of possible actions, or, in other words, greater freedom. However, this latter situation inherently produces a greater degree of uncertainty about the individual's actions. In short, within forensic psychiatry greater freedom produces greater uncertainty, which leads to more intense risk assessment and management practices..

Risk, Danger and Advanced Liberalism

While closely related, a distinction must be made between the terms danger and risk. Danger describes the *exposure* to injury, loss, pain or other evil.[2] For example, an individual brandishing a knife at you represents a danger. On the other hand, risk is a measure of the *possibility* of loss or injury; it is a prospective evaluation of the likelihood and extent of danger. Therefore, risk exists in a context of danger. To continue the example, if you are in a dark alley and the individual brandishing the knife is demanding your wallet, you are at greater risk (i.e., the possibility of injury is greater) than if you are in the kitchen and the individual brandishing the knife is making dinner. Both situations expose the individual to harm, however one situation may be assessed as presenting greater possibility of injury. Garland (2003:50) summarises the distinction between the two terms in the following manner: "Danger is the potential for harm that inheres in a thing, a person or a situation. Risk is a measure of that potential's likelihood and extent. Put at its simplest, risks are estimates of the likely impact of dangers".

In theory, danger is binary. An entity is either dangerous or not dangerous. However, in actuality there is no such thing as 'absolute danger' or 'absolutely no danger', rather danger exists on a risk continuum. More specifically, an individual assesses exposure to a danger and places it on a continuum. Therefore, at one extreme of the continuum, an entity may be assessed as having a low possibility of harm, whereas, at the other end of the continuum, something might be assessed as having a high possibility of harm. To continue the example once again, an infant holding a plastic toy knife could be assessed as an extremely low-risk situation, but yet not completely danger-free; whereas an escaped felon fleeing police holding a knife to your throat demanding your car keys could be assessed as an extremely high-risk situation, but still not a situation that leads to certain harm.

In sum, risks are constantly evaluated by individuals and institutions. Since risk exists in the context of uncertainty, risk assessments may vary over time, across contexts or between assessors. The only constant is the fact of assessment.

Risk is an important feature of advanced liberal modes of governance. Within advanced liberalism, we see a displacement of causal explanations and socially orientated solutions for problems such as crime and mental illness. Instead, there has been a risk identification and prevention orientation that focuses responsibility for health and safety on the individual. Therefore, the main focus of community forensic psychiatric professionals is no longer to simply treat and cure, but also to predict and prevent. Robert Castel (1991) concisely characterises this transformation in psychiatric rationality as the change in focus from dangerousness to risk.

This new risk discourse replaces the notion of danger embodied within a concrete individual with the notion of abstract risk factors which render an unwanted occurrence probable. In practical terms, this has meant that face-to-face interaction between patients and doctors is becoming subordinate to the identification of abstract factors that are deemed liable to produce risk in general. "To be suspected, it is no longer necessary to manifest symptoms of dangerousness or abnormality, it is enough to display what ever characteristics the specialists responsible for the definition of preventive policy have constituted as risk factors" (Castel 1991:288).

Governmental risk-based rationalities can rely on actuarial knowledge of the population as opposed to individualistic knowledge about any one person. In this form of risk prediction, the behaviour, intentions, and motivations of individuals are not the prime concern, but become factors in the statistical and probabilistic determination of risk to security. However, the determination of risk, while always probabilistic, need not necessarily be statistical in nature. For psychiatric professionals, it may be more relevant to understand risk assessment and management in terms of a particular style of thought. Rose (1998; 2000:332) calls this style of thought 'risk thinking' and suggests that it "is concerned with bringing possible future undesired events into calculations in the present, making their avoidance the central object of decision-making processes, and administering individuals, institutions, expertise and resources in the service of that ambition". Ultimately, the objective of risk-based governmental rationalities is the manipulation of thoughts and conduct defined as 'risky', with the ultimate goal of increasing security.

The primary security function of forensic psychiatry is to assess and manage a particular type of risk. Here, risk takes a "peculiar" form (Pilgrim and Rogers 1999:xiv). Rather than concentrating on the potential risks that the subject *faces*, risk within forensic psychiatry focuses on the risks that the subject *poses*. The Board of Review system places individuals found Not Criminally Responsible on a risk continuum. At one extreme, some individuals found NCR are deemed very dangerous and highly likely to cause harm. These individuals are officially considered "high risk" with the result that they are detained in the inpatient facility. At the other extreme, some individuals are deemed not eminently dangerous and very unlikely to cause harm. These individuals are considered "low risk" and can be granted an absolute discharge. Thus, the Board of Review frames individuals found Not Criminally Responsible in terms of the risks that they pose. In this system, risk thinking both produces knowledge to assist in governing an individual, and applies a label that facilitates the categorization of the individual.

Over approximately the last three decades, in a process that roughly corresponds with the increased use of outpatient psychiatric facilities, risk discourses have become central to governing criminal insanity. In identifying and managing risk, psychiatric professionals strive to bring ambiguous, uncertain and possibly dangerous situations under greater control. Risk thinking comes to characterise the rationalities and techniques for governing individuals found Not Criminally Responsible.

However, within contemporary approaches to governing risk, a subtle shift can be identified. As Rothstein (2006a:216) asserts, "we are no longer simply concerned with the governance *of* risk, but we are now in an era of governance *by* risk" (emphasis in original). Rothstein and his colleagues (2006a, 2006b) distinguish two distinct ways in which risk has become embedded within strategies and tactics of governance. The first set of risks are termed 'societal risks' and comprise the more traditional risks such as threats to health and safety, to financial products, to privacy, and so forth. The second set of risks are termed 'institutional risks' and comprise the threats to organisations responsible for governing societal risks. The latter set of risks may include liabilities, bureaucratic failure and/or threats to legitimacy and reputation (Rothstein 2006a:216). These two types of risks are engaged in a dynamic and reciprocal association where attempts to manage societal risks generates institutional risks, which leads to further attempts to manage the societal risks. This sequence is perpetual, as attempts to manage societal risks are imperfect and are thus constantly failing, producing further institutional risks.

Not all societal risks produce the same degree of institutional risk. Individuals that present dangers that have the potential to produce severe consequences for the institution (e.g., re-offence, media attention, etc.) will come under greater regulation regardless of the probability of the danger occurring. On the other hand, individuals that present dangers that carry a low consequence for the institution (e.g., patient being evicted from a residence) will receive less regulation even if that event is more likely.

The next section explores the specific procedures involved in calculating and governing risk within the Board of Review system – a system that involves both the attempts to manage the societal risks posed by individuals found Not Criminally Responsible and the institutional risks involved in this process.

'Risk Thinking' Within Forensic Psychiatry

One of the primary roles of psychiatry within the Board of Review system is to identify and advise the Board of both the dangers and risks that individuals found Not Criminally Responsible present either to themselves or the general public. Here, I am concerned to examine three tasks carried out by forensic psychiatry: 1) organisational procedures put into place for psychiatric professionals to *consider and communicate* risk to the Board of Review; 2) specific techniques that are utilised by psychiatric professionals to *assess* risk; and 3) the strategies put into place to *manage* the risks posed by the Not Criminally Responsible.

Considering and Communicating Risk

As outlined in the *Criminal Code of Canada*, at least once a year, every individual found Not Criminally Responsible must appear in front of and have their case reviewed by the Board of Review. In addition, approximately one month before the individual's Board of Review hearing, psychiatric professionals hold a Pre-Board Conference. This latter conference provides, first, the opportunity for psychiatric professionals to consider the dangers and risks posed by an individual found NCR, and second, it also provides the mechanism through which psychiatric professionals relay opinions of dangerousness and risk to the members of the Board of Review.

At the Pre-Board Conference, the psychiatric professionals first discuss the individual's case, then invite the individual into the conference room and interview him/her about their treatment program, daily activities, life circumstances, and the like. At the conclusion of the Pre-Board Conference, after the patient has been interviewed by the treatment team and dismissed from the room, the treating psychiatrist will ask each team member their opinion of the case. After each psychiatric professional has had the opportunity to provide input, the psychiatrist then writes a report which is sent to the members of the Board outlining the dangers and assessing the risks that the individual presents. For example, the psychiatric professionals might determine that the individual regularly fails to self-administer psychiatric medications and would assess this behaviour as a risk to re-offend or relapse. The Board of Review receives the opinions of the psychiatric professionals, interviews the individual found Not

Criminally Responsible and then decides where to place the individual on the risk continuum. As the individual found NCR becomes more known and his/her behaviours become more predictable and less of a concern, the Board of Review will loosen the conditions imposed upon the individual.

The current Pre-Board Conference procedures arise out of the goal of managing both the societal and institutional risks posed by individuals found criminally insane. These specific procedures evolved out of the recommendations made in a report commissioned in the late 1970's by the Alberta Government (Earp 1977). The commissioning of the *Earp Report* was the result of an incident that occurred in the mid 1970's when the Board of Review recommended the discharge of an individual found criminally insane and that individual subsequently committed a murder in the community. The investigation of this incident revealed that the psychiatric professionals who dealt with the individual on an ongoing, daily basis (i.e., nurses, social workers) believed him to be extremely dangerous and a high risk to re-offend. However, the individual presented a very different portrait to the treating psychiatrist and to the Board of Review. At that time, the treating psychiatrist was the only individual who reported directly to the Board on such matters. Consequently, the nurses and social workers believed that the individual was extremely dangerous and likely to re-offend, whereas the psychiatrist and members of the Board of Review reached the opposite conclusion. As a result of this incident, the Pre-Board Conference was established which brought about changes in how danger and risk are considered by the psychiatric professionals and communicated to the Board of Review.

The advent of the Pre-Board Conference indicates a shift in the role and purpose of forensic psychiatry. Within the Board of Review system, psychiatry could be seen as less a diagnostic and treatment modality than an administrative function to assess and manage risk. This function renders psychiatry increasingly technical. The goal of forensic psychiatry, as demonstrated in the Pre-Board Conference, is to visualize the dangers presented by individuals and assess the risks that these dangers pose. Some of the most common factors in determining the individual's position on the risk continuum include: psychiatric history, severity of index offence, family history of mental illness, compliance in taking psychiatric medications, and acknowledgement of mental illness.

The procedures involved in considering and communicating risk shape the practices and procedures of the forensic psychiatric clinic. As Ericson and Haggerty (1997) argue in relation to police work, day to day tasks are "structured by the categories and classifications of risk communications and by the technologies for communicating knowledge internally and externally. The communication formats provide the means through which the police think, act, and justify their actions" (*ibid*:33). To transpose Ericson and Haggerty's observation to the present research setting, everyday tasks relating to patient care and control undertaken by psychiatric professionals are shaped into formats designed to determine and communicate risk.

The Pre-Board Conference procedures discussed above are a clear example of risk communication processes. At the Pre-Board Conference, after interviewing the individual found NCR, the psychiatric professionals discuss how to communicate risk to the members of the Board of Review. The following interaction highlights a typical conversation at a Pre-Board Conference regarding the communication of risk:

> Psychiatrist: What are we going to recommend?
> Nurse: I wouldn't oppose an absolute discharge.
> Psychiatrist: Then we have to prove to the Board that this man is safe. My main concern is that he feels that he doesn't need meds [medications].

This brief interaction places the individual on the risk continuum (i.e., low risk, could be considered for absolute discharge), but also identifies risk factors that might affect the danger the individual poses (i.e., not taking prescribed medications). The task for the psychiatric professionals is to reconcile risk factors with a level of risk and communicate these findings to the Board of Review.

Day to day routines are also structured with an eye toward risk communication with the Board. For example, at a case conference, a psychiatrist commented: "We should run a blood and med check on him. I'm sure he's OK, but the Board will ask about it". This example demonstrates that psychiatric professionals shape how they think or what they do with a patient in anticipation of communication with the Board of Review. The following subsection looks in more detail at how psychiatric professions determine the risk posed by an individual found NCR.

Assessing Risk in a Forensic Psychiatric Outpatient Clinic

One of the main tasks of forensic psychiatry is to determine where on the risk continuum an individual should be placed. The following explores specifically *how* this task is accomplished. There are two predominant techniques of risk thinking within the forensic psychiatric outpatient setting dealing with individuals found Not Criminally Responsible. The first makes use of clinical risk assessment procedures. This form of risk assessment involves psychiatric professionals utilising informal procedures, intuitive processes, and/or "gut-level inferences" (Ægisdóttir et al 2006) to ascertain the level of risk posed by a subject. Clinical risk assessments arrive at risk probabilities through the subjective practices of psychiatric professionals. The second form of risk thinking utilises actuarial or structured risk assessment instruments in identifying risk. This entails inserting information regarding the subject into a formula such as a table, survey or scale which translates the information into a numerical score indicating probability of danger that the subject represents. Part of the appeal of risk assessment instruments is that they arrive at a risk probability through apparently objective procedures.[3]

Risk assessment entails two distinct tasks which also differentiate actuarial and clinical risk assessment (Hilton et al 2006). The first task involves how the individual completing the risk assessment selects or attends to factors; the second task involves how factors are combined to render an assessment of risk. Thus, items on an actuarial risk assessment instrument are pre-determined through previously conducted empirical studies that correlate specific variables (e.g., employment history, number of previous convictions) to an outcome of interest (e.g., violence, re-offence). Items on risk assessment instruments are combined using actuarial or statistical methods to establish a level of risk. In contrast, clinical risk assessment is based more explicitly on the expertise of the individual conducting the risk assessment. It relies on the ability of the clinician to discover and decide which factors are salient in the evaluation of risk. The clinician combines the collected information in an unspecified manner based on professional experience and preferences. In short, actuarial risk assessment is pre-determined and mechanical operating under the air of objectivity; while clinical risk assessment is intuitive, idiosyncratic and openly subjective. The following sections look specifically at the use of clinical risk assessment procedures, followed by the use of risk assessment instruments in the forensic psychiatric outpatient setting.

Clinical Risk Assessment

Clinical risk assessment is the standard method of assessing the risks posed by patients within forensic psychiatry. As noted above, it is based on the subjective skills, experience, expertise and preferences of the individual conducting the risk assessment. Within clinical risk assessment, the collection of information regarding the patient is not directly specified, standardized or based on an established routine, but rather is gathered idiosyncratically on what the clinician deems is relevant in assessing risk in a particular case. Virtually anything can be considered a clinical risk factor: non-compliance with medication, lack of insight, drug and/or alcohol use, family circumstances, employment situation, gambling, poor diet, forgetfulness, inattention to personal hygiene, excessive attention to personal hygiene, and so on. Information gathered about the individual is translated through psychiatric expertise into predictions regarding the probable actions of the individual.

Clinical risk assessment depends upon disciplinary techniques such as clinical interviews, the review of case records, and the use of clinical judgement to gather information. Various clinical practices provide the opportunity for psychiatric professionals to observe and assess risk factors. For example, the Pre-Board Conference, as discussed above, is in essence a risk assessment procedure. This clinical practice is designed to allow psychiatric professionals to expose and identify risk factors which leads to an assessment of risk. The typical Pre-Board Conference will begin with the psychiatric professionals discussing the medical, legal, psychiatric, and family histories of the patient in order to establish factors that might be considered a risk. Next the patient is brought into the conference room and asked a series of questions that reinforce this assessment of risk. Standard questions the patient is asked include:

- How have you been doing over the last year?
- How do you spend your day?
- What do the medications do for you?
- What would happen if you stopped the medications?
- What would change if you were granted an absolute discharge?

The patient's response to these types of questions provides the grist upon which the psychiatric professionals base their assessments of risk and the recommendations they provide to the Board of Review. The following example illustrates the clinical risk procedures of a typical Pre-Board Conference. In this case, the individual was found Not Criminally Responsible for an unprovoked violent attack on a person of a visible minority. The clinical team believe that the individual still presents a danger to persons of this visible minority and is at significant risk to re-offend. They assess the individual as having little insight into his psychiatric condition and not compliant with taking psychiatric medications. Through the use of clinical procedures, the psychiatric professionals uncover evidence to confirm this risk assessment.

After discussing the individual's index offence, psychiatric history, medical history and daily routine, the psychiatric professionals discuss the case and what they will recommend to the Board of Review:

> Psychiatrist: He's insightless as the day is long … (to each team member) What do you recommend?
> (Several team members each reply): No change (to warrant conditions).
> Psychiatrist: So we don't trust him to not take his meds?
> Therapist: No – he'll stop meds and go psychotic.
> Psychiatrist: I'm certain he would start drinking and go off the meds if he was off the warrant.

Following this discussion, the patient is brought into the conference room and asked a series of questions:

> Psychiatrist: How do you feel about your meds?
> Ron: OK.
> Psychiatrist: Any difficulty remembering (to take) your meds or side effects?
> Ron: No side effects and I'm taking them.
> Psychiatrist: Are you going to have a lawyer at the Boards?
> Ron: Yes.
> Psychiatrist: What will you ask for?
> Ron: Absolute discharge.
> Psychiatrist: What difference will it make getting off the warrant?
> Ron: I could drink a little – would be nice.
> Psychiatrist: Would we see you much?
> Ron: Yeah.
> Psychiatrist: How often?

> Ron: Once a month.
> Psychiatrist: Would you continue to take medication?
> Ron: Yeah.
> Psychiatrist: Are you convinced (that you would continue medications)?
> Ron: Yes.
> Psychiatrist: What does it (medications) do for you?
> Ron: People say it's good to take it.
> Psychiatrist: Does it help you?
> Ron: Probably.
> Psychiatrist: Probably or likely?
> Ron: Likely.
> Psychiatrist: What does it do for you?
> Ron: They say it gets rid of the bad thoughts.
> Psychiatrist: Be more specific.
> Ron: I won't do it (index offence) again.
> Psychiatrist: Why did you do it in the first place?
> Ron: I just did it.
> Psychiatrist: Do you remember why you did it?
> Ron: I figured I'd get rid of him (victim).
> Psychiatrist: Do you have thoughts like that now?
> Ron: No.
> Psychiatrist: What do you think about (visible minority group of victim)?
> Ron: I don't think about it.
> Psychiatrist: I'd like to hear more.
> Ron: I don't think I'd carry a knife anymore.
> Psychiatrist: Do you worry that the thoughts come back?
> Ron: They do come back, but I don't act on it.
> Psychiatrist: That's why it's important to take your meds.

The interview portion of the Pre-Board Conference is utilised to expose and accentuate issues that the psychiatric professionals believe are risk factors. There is virtually no way for the patient to answer these type of questions that does not reinforce the position of the psychiatric professionals. Providing answers that supports the clinical judgments of the psychiatric professionals reinforces their assessment of risk. On the other hand, providing answers that contradict their position is interpreted by the psychiatric professionals as indication of mental illness or lack of insight, which are of course considered significant risk factors. In the particular case described above, after the line of questioning, the patient is dismissed from the room, the case is briefly discussed, and one of the psychiatrists succinctly sums up the proceedings by saying, "He's still crazy" – a conclusion that had been reached before the patient was interviewed.

Other clinical practices such as clinical appointments, family therapy sessions, and occupational or recreational therapy groups also provide the psychiatric professionals with the opportunity to observe, interact and/or question the individual found Not Criminally Responsible. Information acquired through these disciplinary techniques is brought to the weekly case conference where the psychiatric professionals discuss each case, determine the level of risk that the patient represents and plan a course of action in regard to this level of risk. For example, the following exchange is taken from a case conference where two psychiatrists discuss the case of an individual recently found Not Criminally Responsible:

> Psychiatrist #1: Does he have a family history of mental disorder?
> Psychiatrist #2: Yes, particularly paranoid symptoms.
> #1: What has been the effect of medications?
> #2: When he is on meds he is better and antisocial behaviours decline. What he told me was that he had stopped his medication before his index offence and was taking cannabis as well – but not just prior to the index offence.
> #1: Has he been on probation before?
> #2: I asked many times for his criminal record but never got it, but he says that this is the first time he has been in trouble as an adult.
> #1: Has he been compliant with (the legal) conditions?
> #2: Since I've been seeing him, he's been compliant – I think this incident was a shake up for him. (He has) early stages of insight. However, anyone treating him would have to be vigilant about a relapse … his prognosis isn't great.

Within this discussion, the two psychiatrists review many of the standard clinical risk assessment factors such as: family history of mental illness, compliance with psychiatric medications, use of illicit drugs, history of deviance, compliance with institutional conditions, and insight. Despite the patient's fairly favourable position in relation to these risk factors, the second psychiatrist, using subjective clinical judgement, assesses the patient to be a risk for relapse.

In another example of clinical risk assessment, the following comment, made by a psychiatrist at a case conference, represents a much more subjective risk assessment:

> I don't **not** want to hear about (name). He's a scary dude. I don't have good vibes about him. If there's anyone who will commit a homicide in the community, it's him.

Unlike the previous example, where the call for vigilance regarding the patient was made after the review of a number of potential risk factors, the latter psychiatrist was much less guarded about basing a course of action on a subjective imputation of risk. In this case, calls for extra attention to and surveillance of the patient are based on the 'vibes' that the psychiatrist has regarding this particular individual.

All of the above examples demonstrate the subjective nature of clinical risk assessment. Within the Board of Review system, it is the responsibility of the forensic psychiatric professional to assess the potential risks presented by those found Not Criminally Responsible. The subjective nature of clinical risk assessment raises several issues. First of all, in order to minimize the institutional risks presented by the endeavour of predicting the behaviour of the criminally insane, forensic psychiatric professionals generally tend to be conservative in assessing risk. The conservative quality of clinical risk assessments both accentuates the perceived potential societal risks presented by individuals found NCR, and safeguards the psychiatric profession from institutional risks. However, this comes at the expense of the freedom of the individual found Not Criminally Responsible.

In addition, as Menzies (1989) has demonstrated, through the process of conducting assessments, psychiatric professionals may construct imputations of dangerousness. Factors that may have little or nothing to do with re-offence or relapse are often assessed as indicators of dangerousness. As highlighted above, once specific risk factors are associated or fixed to the identity of a patient, it is virtually impossible, or at best a slow and laborious project, for the individual found Not Criminally Responsible to establish an alternative identity.

However problematic the practice, the elimination of subjective clinical judgement from psychiatric procedures is a very unlikely proposition. Assessing risks and determining the probability of dangerous behaviour is the *raison d'être* of the forensic psychiatrist. As Menzies (1989:187) points out, "the eradication of dangerousness from forensic decision-making could well render clinical assessments largely irrelevant to the pragmatic business of producing criminal court dispositions". In the "business" of psychiatry, the use of subjective clinical judgement, as expressed through practices of expertise, is not only a safeguard against institutional risks, but is also what distinguishes the profession of psychiatry from simple common sense or everyday lay perspectives.

Actuarial / Structured Risk Assessment Instruments

While clinical risk assessment is a ubiquitous form of risk assessment within the discipline of psychiatry, the use of risk assessment instruments is less common, but has become more prevalent over the last couple decades. Within this particular forensic psychiatric outpatient setting, one psychiatric team that deals with individuals found NCR regularly makes use of risk assessment instruments, while the other psychiatric team rarely makes use of risk assessment instruments. In other words, one team assesses risk using a combination of clinic procedures and actuarial/structured risk assessment instruments, while the other team relies mainly on clinical risk assessment procedures. The differences between these two clinical teams can be attributed to the preferences of the lead psychiatrist on each team. Consequently, the following discussion focuses mainly on the clinical team that utilises risk assessment instruments.

Several risk assessment instruments have been developed for use with the forensic psychiatric population. These instruments can be categorised into two broad groups: actuarial risk assessment instruments and structured risk assessment guides.

Actuarial Risk Assessment   Actuarial risk assessment instruments allow one to assign a subject to a specific risk category (e.g., high, medium or low risk) by comparing characteristics of the subject to reference data collected from a specific population. As introduced above, actuarial forms of risk assessment focus on the use of quantitative or statistical calculations of variables collected from a population to predict future behaviour of an individual. As Castel (1991) notes, this form of risk assessment utilizes the systematic pre-detection of abstract factors with the goal of minimizing or eliminating future risks. In this way, individuals whose circumstances match statistical profiles can be identified, defined as 'at risk', and treated, managed or controlled accordingly. In short, this way of risk thinking approaches danger as an entity that can be quantified and calculated into levels of risk.

In the Alberta Board of Review system, actuarial risk assessment instruments are commonly used in the inpatient setting when the person is first assessed for criminal responsibility and/or before the individual found Not Criminally Responsible is discharged to the community. Two actuarial risk assessment instruments are commonly used with criminal and psychiatric populations. First, the *Level of Service Inventory-Revised* (LSI-R) (Andrews and Bonta 1999) is an instrument used to predict recidivism based on a reference group consisting of inmates who were released to the community. The LSI-R is a 54 item instrument that is divided into 10 sub-categories (i.e., criminal history, education/employment, financial, family/marital, accommodation, leisure/recreation, companions, alcohol/drug problem, emotional/personal, and attitude/orientation). The clinician rates each of the 54 items in either a "yes/no" format (e.g., Arrested under age 16), or using a 0-3 scale where 0 represents a "very unsatisfactory situation" and 3 represents a "satisfactory situation" (e.g., Could make better use of time). Every instance of a "yes" response or a rating of 0 or 1 receives one mark towards a total score. Total scores above 40 represent "high risk" and correspond to a 76.0% chance of re-offence based on the individuals in the reference group with similar scores who re-offended. On the other extreme, total scores of less than 14 represent "low risk", with a 11.7% chance of re-offence based on individuals in the reference group.

The other common actuarial risk assessment instrument is the *Psychopathy Check List-Revised* (PCL-R) (Hare 1991). The PCL-R is a 20-item rating scale designed to assess psychopathic personality disorders in forensic populations. Since psychopathy is seen as predictive of violent behaviour, this scale is also widely used to identify risk. PCL-R ratings are made by a clinician on the basis of a semi-structured interview and a review of collateral information (e.g., case records). The PCL-R scale includes items such as "Parasitic Lifestyle", "Superficial Charm" and "Promiscuous Sexual Behaviour". The clinician scores each item with a "0" if the item does not apply to the individual, "1" if the item somewhat applies and "2" if the item definitely applies. The scores on all the items are tallied and individuals with a total score over 30 are considered psychopathic. Therefore, the higher the PCL-R score, the more potentially dangerous, or higher risk, the individual is considered.

Structured Risk Assessment Guides Other risk assessment tools could be described as structured guides. Structured risk assessment guides generally contain approximately one or two dozen variables that are thought to be relevant when assessing risk. For example, the *HCR-20* (Webster et al. 1997) is a risk assessment guide that assesses the risk for future violent behaviour in criminal and psychiatric populations. The scale contains 20 items divided into three categories: 1) *Historical* variables (e.g., Relationship Instability); 2) *Clinical* variables (e.g., Negative Attitudes); and 3) *Risk* variables (e.g., Plans Lack Feasibility). Clinicians assign the subject a score of "0" if the variable is not present or not relevant for the subject; a score of "1" if the characteristic is partially or possibly present; and a score of "2" if the characteristic is definitely present. The score for each individual item is then tallied and the final score provides the basis upon which the clinician makes a risk judgement regarding the subject.

One of the most common scales used in psychiatry is the Global Assessment of Functioning (GAF) scale (American Psychiatric Association 2000). The GAF scale is a numeric scale that ranks individuals from 0 through 100 based on the social, occupational and psychological functioning of the individual. An individual with fewer psycho-social difficulties is ranked higher on the scale. For example, an individual whose "behaviour is considerably influenced by delusions or hallucinations OR serious impairment in communication OR inability to function in almost all areas" would receive a score between 21 to 30. Whereas an individual who has "absent or minimal symptoms, good functioning in all areas … interested and involved in wide range of activities, socially effective, generally satisfied with life, no more than every day problems or concerns", would receive a score between 81 to 90.

Within this setting, a GAF score is generated and noted on the individual's file approximately once per year. Often the GAF score is assigned or reviewed at the completion of a Pre-Board Conference or Individual Care Plan Meeting. Usually, the GAF score given at the previous meeting is noted and a sharp decrease in score would be taken as an indicator of increased risk. However, because the GAF score does not deal with specific circumstances of the individual, but rather "global functioning", a decreased GAF score could only signal a non-specific increase in risk. The GAF scale is not intended to be a risk assessment instrument, however, extreme variations in GAF score are often perceived by psychiatric professionals as indicators of an increased or decreased level of risk.

The use of both actuarial risk assessment instruments and structured risk assessment guides are common practice within forensic psychiatry. However, the use of these tools raises some important issues. Of particular interest, is how risk assessment tools standardize the clinical gaze, provide a veneer of objectivity and mask uncertainty in the assessment process.

Risk assessment instruments focus the clinician's attention only on the particular aspects of the patient's life that previous research has correlated with violent behaviour or re-offence. This standardization of the clinical gaze provides the appearance of objectivity when completing a risk assessment. Since only statistically significant items are attended to, risk assessment tools appear to eliminate any bias that may be introduced by the clinician completing the instrument. As Rose (1998:191) maintains, the use of risk assessment instruments "does not only serve to increase the appearance of accuracy … it also serves to decrease contestability and to imply specious precision".

Despite the objective appearance of quantitative assessment instruments, the completion of these scales is a subjective exercise. Even if the instrument limits the clinician's attention to particular elements of the patient's life, the assessor must still decide to what degree the item in question is relevant to the patient's circumstance (e.g., "somewhat applies" or "definitely applies"). In addition, the assessment of some items could be subjective to cultural norms or standards that may differ between the clinician and the patient (e.g., "Subject lacks realistic goals"). Consequently, risk assessment instruments are the vehicles through and around which subjectivity comes into play. As a result, within this research setting, psychiatric professionals often assess the same individual with a wide variation of scores. For example, at one Pre-Board meeting there was a 40 point discrepancy in GAF score given by two psychiatric professionals for the same subject.

In addition, the scores on risk assessment tools are often mitigated by clinical judgement. In some cases, if the risk assessment score that the instrument provides does not match with the judgements of the clinical team, they will revise the score on one or more of the instrument's items to better reflect what they see as the individual's 'true' risk level. In other words, the results of these instruments are not taken as 'objective truths', but are rather subject to interpretation. In other cases, the risk instrument is completed, and the resulting score is all but ignored. The instruments are completed, as one staff member remarked, "to satisfy the bean-counters". These examples demonstrate that both disciplinary and actuarial types of risk thinking not only co-exist but also interact and react with each other. One risk assessment rationality does not necessarily take precedence over the other.

The supposed objectivity of numbers provides security to psychiatric professionals when faced with having to make predictions regarding the behaviour of patients. Rationalities based in numerical and calculative procedures are seen by psychiatric professionals to augment the decision-making process, irrespective of the methodological validity of the instruments themselves. Porter (1995) argues that professionals turn to the use of numbers when they feel the need to justify their judgements and decisions. He further argues that the recourse to numerical or calculative rationalities can be taken as a sign of weak institutions. In other words, psychiatric professionals use risk assessment tools when faced with situations of high institutional risk. In these circumstances, risk assessment instruments objectify danger into calculable risks in order to alleviate threats to the profession or institution.

Individuals found NCR who are discharged to the community present potentially more uncertainty than those detained in an inpatient setting. Consequently, risk assessment instruments provide psychiatric professionals the opportunity to govern individuals with an air of objectivity by masking uncertainty in regard to both the behaviour of the individual in question as well as masking the uncertainty of risk assessment procedures more generally.

Ultimately, the goal of both clinical and actuarial risk assessment is "to attach risk to the bodies of individuals so they might become objects of more intensive surveillance and treatment" (Dean 1999:190). Psychiatric risk assessment seeks to minimise risks through either the subjective methods of disciplinary practices (i.e., clinical risk assessment) or through the apparently, but not entirely objective method of rendering risk numerical (i.e., actuarial risk assessment). Either way, it is the responsibility of forensic psychiatry to assess and manage the risks presented by the criminally insane. The following section outlines the various risk management strategies that are utilised in the forensic psychiatric outpatient clinic.

Managing Risk in the Forensic Psychiatric Outpatient Clinic

Risk management strategies attempt to reduce danger through the manipulation of the conduct, thoughts, beliefs and behaviours of those deemed 'risky'. The ultimate goal of these techniques is to decrease both the societal and institutional risks presented by individuals found Not Criminally Responsible. Within forensic psychiatry, the aim of risk assessment strategies is to determine which individuals can or cannot be managed in the community. Those that are deemed unmanageable in the community are held or returned to the inpatient facility until the time they can be managed in the community; those individuals that are deemed manageable in the community are discharged and face the tactics described below.

Observation of the daily routines within forensic psychiatry suggests that psychiatric care is undergoing a reconfiguration of function, namely, from primarily a concern with treatment and cure, to an emphasis on the secure containment of risk. This shift is reflected in Alberta Hospital Edmonton Forensic Psychiatry Program's brochure which lists the goal of the inpatient unit as the "safe re-integration (of patients) into the community". In short, psychiatric management shifts from the administration of treatment to the administration of risk.

Different strategies and techniques of governance are put into place depending on where on the risk continuum an individual is placed. “The essence of risk management lies in maximizing areas where knowledge – and hence control – are possible, while avoiding areas that are less known and less predictable” (Garland 2003:68). Individuals that are assessed as possessing high levels of risk are detained in the inpatient facility. Individuals thought to be high risk are those who are unknown within the Board of Review system (i.e., those recently found Not Criminally Responsible), or those whose recent behaviour or demeanour is erratic or presents concerns for either the Board of Review or the psychiatric professionals. In other words, ‘unknown’, ‘uncertain’ or ‘unpredictable’ are equated with high risk. “Confinement becomes little more than a way of securing the most risky until their riskiness can be fully assessed and controlled” (Rose 1998:184). The inpatient facility affords psychiatric professionals the opportunity to closely interact with the patient. Within this setting, the personal history and characteristics of the individual become known, and the individual has the opportunity to present consistent (i.e., predictable) behaviour and demeanour to psychiatric staff. Over time (e.g., often several years), the individual may eventually be placed at a different position on the risk continuum.

At the other end of the risk continuum, individuals that are assessed as possessing low levels of risk are those individuals who are both well known within the Board of Review system and whose current behaviour and demeanour is consistent and does not present any concerns to psychiatric staff or Board of Review members. In other words, individuals who are well known and predictable are considered a lesser risk. These individuals are commonly discharged to the community and required to attend regular (e.g., weekly or monthly) appointments at the forensic psychiatric outpatient clinic. An individual found NCR who is considered to pose a low risk for a significant amount of time (e.g., several years) will usually be considered for an absolute discharge.

In between these two extremes on the risk continuum lie many possible scenarios. For example, an individual found Not Criminally Responsible may be detained in the inpatient facility, but be granted lenient conditions that include unsupervised leave of absences from the hospital.[4] Other individuals will be discharged to the community, but are required to abide by strict conditions that include daily appointments at the forensic outpatient clinic.

When an individual is discharged to the community, the focus of the risk assessment and management activities shift. At the time of discharge, the individual has likely been involved with the Board of Review system for several years, and is therefore well known to the psychiatric professionals. However, as discussed above, compared to the inpatient, the range of possible behaviour of the outpatient is greater while the amount of contact between psychiatric professional and patient is less. Therefore, the focus of risk assessment and management activities shifts from gaining knowledge of personal characteristics (e.g., historical factors) to predicting the behaviour of the individual and governing the risks these potential behaviours may pose. In the outpatient setting, psychiatric professionals attend to current situations of patients that might be considered predictive, such as drug/alcohol abuse, family difficulties, and non-compliance with psychiatric medication, to name just a few. Any concerns or inconsistencies that arise in these or any other area will likely result in the individual being considered 'at greater risk' and will consequently result in some sort of risk management strategy.

Within this research setting, risk management techniques fall within a wide range of strategies that may be classified on a continuum from more formal to less formal techniques. For example, within the forensic psychiatric outpatient clinic, formal risk management techniques include, of course, the use of psychiatric interventions. In particular, the use of psychiatric medication is ubiquitous in the regulation of risk. The dosage or type of medications is altered depending on the perceived level of risk that the individual presents. In case conferences, if the current behaviour of a patient presents a concern, the clinical team will discuss the merits of a change in medications. In the following example, a nurse describes an interaction with a patient:

> Nurse: He's so happy now. I asked him, "Why are you so happy?", and he said, "I'm just in a good mood".
> Psychiatrist: We need to check his meds.

As this example demonstrates, the use of psychiatric medications is often the first and most common form of risk management technique utilised in this setting. Virtually every individual found NCR is prescribed psychiatric medication and any behaviour that creates uncertainty with the psychiatric professionals results in a review, and often modification, of the patient's medications.

The other main form of psychiatric intervention is the clinical appointment. As noted above, the clinical appointment is a risk assessment procedure, but it may also be used as a risk management technique. When an individual found NCR appears to be at a greater risk, one of the first risk management techniques is to arrange a face-to-face meeting with a clinical staff member, often the psychiatrist, as demonstrated in this example:

> Nurse: (Name of patient) wants to see his file. He's getting paranoid.
> Psychiatrist: I usually just read a few pages (of the file notes), then their eyes glaze over and they say: "That's what the nurses write?" and I say, "What did you expect". Make an appointment for him with me.

The vast majority of face-to-face contact between psychiatric professionals and patients occurs at the outpatient clinic. However, on occasion, psychiatric professionals may also visit the residence of a patient. This type of intervention provides the opportunity for the psychiatric professional to contact patients who might be refusing or reluctant to come to the clinic for an appointment. Thus, home visits combine risk management techniques with the opportunity to surveil the personal living quarters of the patient. In the following interaction, which occurred at a case conference, psychiatric professionals discuss a patient whose psychiatric medications were recently changed and who also missed his last clinical appointment at the clinic.

> Psychiatrist: This is very odd. He never misses an appointment or an injection. We should phone him to find out what's going on.
> Nurse: I called him the other day, but he didn't return the call.
> Psychiatrist: That's even worse. He gets psychotic very quickly. We should go see him.

In this example, several factors (i.e., change in medications, missed appointments, not returning phone calls) combine to suggest that the patient presents a greater risk. The home visit is a direct risk management technique in response to the perceived danger.

Drug or alcohol testing is another risk management technique utilised by psychiatric professionals. In the following example, the psychiatric professionals discuss whether to grant an extended pass to a patient that would allow him to travel outside the city to spend the holidays with his family.

> Psychiatrist: Anytime he was out (on an extended pass), he did drugs. However, he has met all our conditions – he attended drug rehab, he was discharged from the hospital – so I think he should (get an extended pass).
>
> Nurse: But I think he should go straight to the hospital afterwards for a drug test.
>
> Psychiatrist: We should run a blood and med check on him. I'm sure he'll be OK, but the board will ask about it.

This example demonstrates that drug testing is utilised as both a risk management technique in response to the potential societal risks presented by this particular patient, but also as a response to the institutional risks that are associated with allowing this patient travel outside the city for an extended period of time. In this situation, a drug test will provide the assurance that the psychiatric professionals have carried out the necessary precautions to insure that the patient does not present an increased risk to society as a result of the extended pass.

Another obvious risk management technique involves the formulation of legal conditions that the individual found Not Criminally Responsible must abide by. Only the Board of Review can impose legal conditions on the individual, however psychiatric professionals make recommendations to the Board regarding conditions they feel are appropriate or necessary to manage the individual in the community. Legal conditions imposed upon the individual become an efficient and easy way for the psychiatric team to manage 'risky' individuals in the community. The following discussion occurred at a Pre-Board Conference concerning an individual about to be discharged to the community. After interviewing the patient, who had committed an offence involving a weapon, the clinical team discusses what conditions they will recommend to the Board:

> Psychiatrist #1: He's ours now, what should we do with him?
> Psychiatrist #2: Definitely continue with the weapons ban.
> Therapist: Full warrant with conditions to live in the community. No weapons, no alcohol.
> Nurse: Visits (to FACS) - I think weekly to begin with.
> Psychiatrist #1: No one wants to give him conditional discharge? (Everyone says 'No'.) Good.
> Psychiatrist #2: What about drug tests?
> Psychiatrist #1: I think we should have that right in the conditions. So is everyone happy with a full warrant and include alcohol testing.
> Psychiatrist #2: Definitely.

Here, the recommendation to the Board that the individual be held under a full warrant with several conditions facilitates the risk management strategies of the psychiatric professionals.

Finally, of all the formal risk management techniques available to the psychiatric professionals, possibly the simplest and most effective technique is to re-admit the individual discharged to the community back to the inpatient facility. Patients discharged to the community are readmitted to the inpatient unit when circumstances arise that are seen by the psychiatric professionals as creating uncertainty. These circumstances may include changes in behaviour, attitude, or demeanour that result in the individual being considered a greater risk. As one psychiatrist explained: “On the abundance of caution, we took her back into hospital for about a week”.

In addition to the formal risk management techniques described above, psychiatric professionals also utilise informal techniques. These less formal techniques frequently include individuals closely involved in the patient’s life. For example, family members of the patient or group home workers where the individual resides are often notified when troublesome situations arise. A staff member will contact and ask these individuals to ensure, for example, that the patient takes their medication, or attends clinical appointments. By recruiting these individuals to perform risk management techniques, psychiatric professionals create a network of risk management that can encapsulate virtually every moment and aspect of the patient’s life.

One final risk management technique, self-management of risk, is of critical importance within the forensic psychiatric outpatient clinic. For the individual found to be ‘risky’, issues or factors identified as troublesome are neither left to fate nor completely managed by the psychiatric system. Rather, individuals found NCR must themselves become involved in the identification and management of the risks they pose. In this setting, individuals must demonstrate the ability to identify risk factors and manage them appropriately. For example, as discussed in the previous chapter, the patient must demonstrate ‘insight’ in a wide variety of circumstances, such as what conditions may lead to a relapse in mental illness, what interpersonal situations to avoid, what side effects require immediate attention, and so on. "Individuals are invested with the responsibility to manage their own risk and to take responsibility for failures to manage it. Risk management, in this sense, becomes a technique of the prudent self" (Rose 1996b:13-14). Psychiatric professionals are thus required to manage risk through both direct risk management techniques such as home visits, interviews, diagnosis and assessment, as well as through more indirect practices, such as those which inculcate responsibility and prudent self-management in the patient.

Accordingly, the risk management strategies in community forensic psychiatry result in subjectification of individuals through both passive and active forms of governance. Passive modes of governance involve the processes that constitute and constrain the subject from a source external to the subject. Passive governmental techniques include the classification of individuals into risk levels, the application of diagnoses, or the use of dividing practices (e.g., hospitalization) that have the result of excluding the individual from self or others. In general, passive modes of governance are negative in the sense that they are focussed on deficit and concerned with the methods of identifying, controlling, fixing and/or incapacitating an inert subject.

Active modes of governance, on the other hand, involve processes that encourage subjects to constitute or transform themselves. Here, the actor is considered to have agency and the ability to change self. Active governmental techniques include providing opportunities for individuals to take responsibility for their own care, encouraging individuals to accept an identity, or any other activity that promotes active self formation. Events in the forensic psychiatric clinic such as Individualized Care Plan meetings and clinical appointments provide opportunities for interpersonal interactions that encourage these types of self formation. This theme and the techniques involved in active self formation are the focus of Chapter Eight.

Discussion: Risk and the Governance of Criminal Insanity

The preceding sections have analysed the various methods through which risk is assessed, communicated and managed in the forensic psychiatric outpatient setting. Through these pursuits, forensic psychiatry serves as a technique of security whose primary function is the detection and management of the societal risks posed by individuals found Not Criminally Responsible. These rationalities of risk come to characterise one of, if not the main strategy through which the governance of criminal insanity is carried out. As Rose (1996b:15) observes, risk management – the group of activities he associates with the identification, assessment, elimination, or reduction of the possibility of incurring misfortune or loss – has become an integral part of the professional responsibility of each psychiatric expert. Indeed, it is through these forms of expertise that psychiatric professionals attempt to make the ambiguous and uncertain qualities and circumstances of criminal insanity known, predictable and thus governable.

However, as suggested by Rothstein (2006a, 2006b), the attempt to govern societal risks creates institutional risks. In deciding to discharge an individual found NCR to the community or to discharge the individual absolutely, the Board of Review and psychiatric professionals are responsible for determining if the individual presents a danger, the likelihood of that danger, and any steps that should be taken to minimize those dangers. Each of these courses of action presents a potential threat to the institution itself. To err is to potentially either endanger members of the general public or, conversely, to unnecessarily hinder the rights and freedom of the individual found NCR. To combat institutional risks, psychiatric professionals increasingly turn to the task of attempting to predict the behaviour of individuals found NCR, rather than just simply providing treatment. As Castel (1991:295) notes, this form of risk thinking is no longer obsessed with discipline but rather with efficiency. The logic of diagnosis is replaced by the logic of prediction, which results in a focus that is perpetually looking to and dealing with the future rather than the past. In other words, as Garland (2003:49) posits, risk becomes the means by which we colonize and control the future.

In the pursuit of predicting and controlling the future behaviour of individuals found Not Criminally Responsible, psychiatric professionals adopt two basic strategies: direct and indirect risk intervention strategies. Direct risk intervention strategies entail specific procedures which psychiatric professionals perform with the goal of providing both societal and institutional security. For example, in the forensic psychiatric outpatient setting, risk assessment procedures that utilise supposedly objective measures of risk prediction are amalgamated with the more subjective clinical risk assessment procedures. The result is a hybrid risk assessment procedure, where clinical risk assessment procedures are substantiated or supplanted with the use of actuarial or structured risk assessment instruments. In short, psychiatric professionals first classify the subjects of forensic psychiatry in accordance to the likelihood of future conduct (i.e., risks posed to themselves or others) and then implement risk management procedures that attempt to govern these dangers.

Indirect risk intervention entails strategies carried out by psychiatric professionals that encourage individuals found Not Criminally Responsible to be responsible for their own governance. Psychiatric professionals instruct patients to identify, attend to, report, cope with and/or manage behaviours and situations that may be considered troublesome or dangerous. Through this process, individuals found Not Criminally Responsible are governed according to the prudent decisions and responsible behaviours that they carry out.

Within this research setting, formal and informal, direct and indirect forms of governance combine to form a fusion of risk assessment and management strategies. This fusion of strategies is often not very straightforward and can be complicated, erratic, and inconsistent. However, no matter how it comes about, the objective of these forms of governance is to place the individual on a risk continuum which, in turn, leads to the imposition of particular tactics, depending on the position on the continuum. Through this fusion of risk governance processes, dividing practices come under a new logic. For example, those individuals found NCR who are not able or willing to govern themselves in a manner acceptable to the psychiatric professionals are considered ‘high risk’ and are subsequently institutionalized within the inpatient setting. In other words, the risks they are thought to pose are predominantly governed through direct means. Conversely, those individuals who are consistently able to govern themselves in a manner acceptable to the psychiatric professionals are considered to present 'extremely low or minimal risk' and are granted an absolute discharge. That is, the risks they pose are self governed and direct methods of risk governance are not necessary. However, those individuals who are placed on the risk continuum in between these two extremes, those amorphously categorised as presenting 'some degree of risk', are discharged from the inpatient facility and maintained in the community. In this situation, some direct forms of governance are considered necessary, but, in addition, psychiatric professionals work to inculcate the individual in the ways of self governance. In this manner, risk mechanisms practiced in this setting incorporate both liberal and advanced liberal governmentalities. Disciplinary modes of governance, such as clinical procedures, fuse with advanced liberal practices, such as encouraging the subject to assess and regulate their own risk factors, which results in a hybrid of risk rationalities and techniques.

In sum, within the forensic psychiatric outpatient setting, risk assessment and management strategies endeavour to make uncertain and ambiguous qualities and situations clear, reliable and known. The goal of risk governance strategies within this setting is to set the subject within a category which moves the individual out of this liminal state, either toward the freedoms of absolute discharge and inclusion in society, or back to detention in the inpatient facility and exclusion from society.

Chapter Seven – Resistance

Individuals found Not Criminally Responsible face powerful and established forms of regulation. Previous chapters have outlined some of these strategies. Initially, when entering the Board of Review system, individuals found NCR are labelled through a potentially stigmatizing form of knowledge/expertise (i.e., psychiatry). Subsequently, they face numerous governmental tactics. For example, individuals found Not Criminally Responsible face legal restrictions on their freedom (i.e., conditions implemented by the Board of Review), and also psychiatric forms of regulation, such as surveillance and risk management strategies.

These practices suggest a considerable imbalance of power. But closer inspection often reveals subtle instances of resistance. However, these acts of resistance do not take the form of an organized or collective movement. Individuals found Not Criminally Responsible are not organizing protests, preparing petitions, or planning a rebellion. In short, there is no grand resistance movement of the criminally insane. Rather, this setting reveals instances of what may be called 'everyday forms of resistance' (see de Certeau 1984; Ewick and Silbey 1998; Gilliom 2001; McCann and March 1995; Rose 1999a:279-280; Scott 1985). Such resistance is not undertaken to make wholesale changes to society or even to the psychiatric or legal systems in which the individual found NCR is involved. This form of resistance is not coordinated and is often somewhat spontaneous. Everyday forms of resistance are carried out for individual purposes. Within the forensic psychiatric outpatient setting, resistance takes the form of actions that oppose strategies or forms of regulation that attempt to guide one's conduct. Common examples of everyday forms of resistance in this setting include: not answering questions, withholding information, lying, not showing up for appointments, and so on. Put simply, everyday forms of resistance are intended to make one's own circumstances more tolerable – that is to make one's life easier or more comfortable.

This chapter explores the relationship between strategies of power and strategies of resistance. It begins with a discussion of resistance as it pertains to forensic psychiatry. In brief, acts of resistance highlight the strategies and tactics[1] of power relations in the forensic psychiatric outpatient setting as well as the capacity of individuals to struggle for independence from psychiatric and legal regulation. Contrary to the position that scholarship should focus on collective resistance movements capable of societal reform (Handler 1992), I argue that everyday forms of resistance are significant and realistic given the extreme power imbalances in forensic psychiatry. These forms of resistance mirror the fragmented, individualized character of advanced liberal modes of governance.

Despite its importance in power relations, there are few empirical studies of resistance, especially within the area of forensic psychiatry. The second section of the chapter describes some of the tactics of resistance utilised by individuals found Not Criminally Responsible in countering power strategies and tactics (i.e., *how* individuals resist power strategies). In short, tactics of resistance can be divided into two general categories: tactics of refusal and tactics of avoidance. Following the description of tactics of resistance, the section explores several particular power strategies that are resisted in the forensic psychiatric outpatient setting (i.e., *what* is resisted). Specific attention is drawn to resistance of psychiatric expertise, clinical and non-clinical psychiatric practices, and resistance pertaining to identity formation.

The chapter concludes with a consideration of the implications of resistance in this setting. Specifically, the findings of this research suggest that, before advancing through the Board of Review system, individuals found Not Criminally Responsible must establish a balance between resisting psychiatric expertise and practices and exhibiting responsible behaviour. Hence, I propose the concept of 'responsibilised resistance' to characterise this balance between resistance and responsibility.

Power and Resistance as Strategic Relations

As discussed in Chapter Three, the scholarship of Foucault and Goffman is divergent yet complementary. Each scholar is interested in the articulation of power through interpersonal interactions. Foucault provides a socio-political discussion of power relations, while Goffman provides a detailed analysis of face-to-face interactions. Both of these approaches contribute to this study of resistance in a forensic psychiatric outpatient setting.

Recall that for Foucault, power does not exist in a substantive sense. It is not possessed by certain individuals or groups, nor is it located at any given site. Rather, for Foucault (1980b:198), "power means relations, a more-or-less organised, hierarchical, co-ordinated cluster of relations". Given this understanding of power, resistance is an essential component of power relations –

"Where there is power, there is resistance" (Foucault 1978b:95). The applications of power (i.e., the sites where strategies and tactics are utilised in an attempt to influence the conduct of others) are also the sites where resistance (i.e., the strategies and tactics that oppose these attempts to influence ones conduct) is possible. In other words, power relations function as both instruments of governance and as points of resistance. Consequently, power and resistance are irreducible elements and cannot exist in isolation, but rather serve as conditions of possibility for each other.

Foucault (1997a:298-9) conceives power relations as 'strategic games'. Acts of resistance do not negate power per se. Rather, to resist is to attempt to escape a particular strategy of power that aims to direct one's conduct and define one in a particular way. In addition, Foucault does not see resistance as forming or existing outside of power relations. Rather, resistance acts as the limit of power. It may be thought of as the underside, the counter-stroke, or "that which responds to every advance of power by a movement of disengagement" (Foucault 1980c:138).

Power relations are therefore not single sided affairs, where one individual or group 'holds' all the power against another individual or group. Instead, power is relational – games of strategy that are infused with potential and struggle in which some try to govern the conduct of others, who in turn try to avoid or subvert such initiatives (Foucault 1982:224-226; 1997a:298-299). Foucault uses the term 'agonistic' to describe the relationship between power and resistance. The word implies "a relationship which is at the same time reciprocal incitation and struggle; less of a face-to-face confrontation which paralyses both sides than a permanent provocation" (1982:222). Therefore, it may be useful to think of power relations not so much as a confrontation, but rather a contest, struggle, or opposition involving strategy, reaction, and counter-reaction. Every power relationship is manifest in strategies and/or attempts to govern conduct as well as recalcitrant acts that attempt to oppose these strategies. Even in dominating power relations, where power may be relatively fixed or asymmetrical, resistance is possible if only in extreme forms, such as flight, violence or suicide.

However, Foucault's assertion that there are no relations of power without resistance is not adequately substantiated (Lacombe 1996:342-3; Simons 1995:83-4). As O'Malley et al suggest, governmentality studies tend to focus on governmental programmes from the programmers' perspective and resistance is "viewed only as obstacle and failure, and, in turn, failure is understood primarily as a source of reform and innovation *by the programmers*" (1997:510-11, emphasis in original).

While Foucault provides a broad perspective of resistance, Goffman's analyses provide detailed descriptions of individual reactions to power strategies within institutions. In his study of the asylum, Goffman (1961) addresses the theme of the 'underlife' of the total institution. He describes how individuals adjust to life within the institution by cooperating and identifying with the aims and goals of the organization. He describes this stance as a "primary adjustment" to the institution. However, Goffman also describes "ways in which the individual stands apart from the role and the self that were taken for granted for him by the institution" (1961:189). These "secondary adjustments", often covert and understated, are attempts by the individual to adapt to or 'make do' within the institution.

Secondary adjustments undertaken by individuals within institutions include strategies such as situational withdrawal (i.e., inattention to events surrounding or involving the individual) and intransigence (i.e., flagrant refusal to cooperate with staff) (Goffman 1961:61-4). Goffman describes how these attempts to adapt to the institution involve the formation and presentation of a self identity. These identities will either be compatible or come in conflict with institutional priorities. Consequently, individuals who form and present identities that are incompatible with institutional priorities are resisting the institutional strategies and objectives that aim to govern them.

Goffman states that individuals are opportunistic in their use of secondary adjustments, drawing on tactics or combination of tactics that best suit the individual. He also describes the "fraternalization process" (1961:56-58) where inmates of the total institution derive mutual support and develop common counter-mores to their shared situation. However, he maintains that most secondary adjustments are individual rather than collective acts of adaptation. Thus, secondary adjustments are tactics of resistance undertaken by individuals in order to improve personal circumstances in reaction to strategies of power that attempt to regulate them.

This chapter analyses specific interactions between individuals found NCR and psychiatric professionals in order to illuminate the interplay between strategies of power and strategies of resistance. As developed at the end of the chapter, successfully negotiating this interplay is essential in order for individuals found NCR to progress through the Board of Review system.

Resistance and Forensic Psychiatry

Within the forensic psychiatric outpatient setting, acts of resistance highlight two important issues. First, the study of resistance brings attention to relations of power. Through examining resistance we may achieve a better understanding of how power functions. Second, the study of resistance highlights the capacity of individuals. Acts of resistance are an important strategy through which individuals actively strive to direct their personal circumstances. Each of these themes will be discussed below.

Resistance and Power

Resistance provides a lens through which power relations, even asymmetrical power relations, may be studied. As discussed earlier, strategies of resistance and strategies of power are the corollary of each other; one does not exist without the other. However, the nature of power relations differs for every power dyad. That is, every power relation brings a different combination of strategies of governance and strategies of resistance. Consequently, in this research setting, there is no common theme to resistance, such as issues of social class, race, or gender. While some patients may talk amongst themselves and share strategies and tactics of resistance, given the minute scale in which these activities take place, the psychiatric and legal systems rarely attribute these actions with any social significance beyond bemusement, annoyance, or simply taking these actions as another indicator of the presence or absence of a mental illness. Therefore, it cannot be said that resistance in this setting is organised or represents a resistance movement. Rather, resistance is individualised, localized, and fragmented as exemplified in the everyday forms of resistance that preponderate – e.g., feigned compliance, lying, procrastination, not showing up for appointments, disagreeing, and the like. Many of these acts may seem petty or trivial, and may even be counter-productive to the individual, considering that resistance tactics are commonly met with counter tactics. However, these are common, time-tested tactics that, given the realities of power relations in this setting, represent the most effective strategies available to individuals found Not Criminally Responsible.

Given the response to resistance in power relations within a forensic psychiatric outpatient clinic, a question begs to be asked: Are everyday forms of resistance significant or important? Joel Handler (1992) notes a shift in academic research over the last several decades that focuses on resistance. He identifies and compares accounts of "protest from below" from two sets of scholars – those that 'predate postmodernism' (i.e., pre c. 1990) and those that are termed 'postmodern' (i.e., post c. 1990). Scholars from the former group work within a more structuralist tradition and identify collective movements which share commonalities of identity, struggle and social vision. The goal of this scholarship is to incite social change within social systems that repress individuals or groups through social class, race, or gender, for example. In contrast, the group of scholars that Handler identifies as postmodern are concerned with even more abstract targets, such as dominant discourses and rationalities. Scholars from this group note that contemporary acts of resistance lack solidarity and a collective identity. Through the process of deconstruction, postmodern scholars work to uncover how the production of knowledge results in the subjugation of individuals.

Handler suggests that postmodern studies of resistance identify a "scattered set of issues, complaints, and demands (and) do not constitute a unified force or vision" (1992:720). Handler criticises these studies for lacking a comprehensive vision of society by dwelling on insignificant actions of those who resist rather than focusing on collective actions that have the possibility of producing social change. "The (postmodern) authors, at best, are extremely reluctant to draw common connections, to talk about the possibilities of collective action in any concrete manner, or even to suggest middle-level reforms, let alone reforms at a more societal level" (Handler 1992:724).

However, Handler's advocacy of scholarship which focuses solely on social movements that are capable of societal change results in a myopic view of acts of resistance. This approach is similar to a Marxist approach, which sees the destruction of the capitalist infrastructure as the only possible goal of social change. Within these perspectives, acts of resistance produce results that can only be viewed as binary, finite, and normative. In Handler's analysis, resistance can only be 'successful' if broad coalition-based social change occurs. If a struggle is successful, social change follows and individuals are freed from repression. However, if such change does not occur, the struggle is not successful, and individuals are still repressed. From this perspective, societal change is the only desirable outcome of resistance. Likewise, if resistance produces social change, the struggle is concluded. In other words, successful acts of resistance produce conditions where resistance is no longer necessary. Finally, within this perspective, broad scale social change (i.e., outcomes beyond individual-level interests) are the only acceptable outcomes of acts of resistance.

Several scholars challenge Handler's view that research on resistance must focus on collective, social movements capable of broad-based social change (see Ewick and Silbey 1998; Gilliom 2005, 2006; McCann and March 1995). These scholars encourage the study of everyday forms of resistance on the basis that these forms of resistance are not only important in bringing about improved circumstances for those who resist, but also reflect contemporary social conditions. For example, Ewick and Silbey (1998) remind us that power strategies and resistance are entwined. They suggest that organised, collective resistance movements that challenge societal precepts are associated with broad strategies of governance such as those associated with the state (e.g., legislative actions). In other words, organised, collective resistance movements are the corollary of grand and visible displays of power.

However, as power relations shift from liberal to advanced liberal forms of governance, forms of resistance also shift. With advanced liberal forms of governance, power relations become more fragmented and individualised. Ewick and Silbey suggest that "the technical, faceless, and individuated forms of contemporary power defy the possibilities of revolt or collective resistance" (1998:188). Contemporary power relations make it difficult to direct acts of resistance at a single entity, such as the state or a disciplinary institution. Therefore, like power itself, resistance takes on fragmented and diffuse forms, such as the everyday forms of resistance analysed below.

As highlighted in previous chapters, the forensic psychiatric system is currently undergoing a shift in power strategies from modes of control exemplified by the disciplinary techniques of the inpatient facility, to strategies of regulation exemplified by advanced liberal techniques, as demonstrated in the outpatient clinic. For example, all patients within the inpatient setting face the same or very similar strategies of regulation (e.g., the control of time and space, constant surveillance, etc.). The homogeneity of these strategies of regulation provides an entity toward which resistance can be directed. Conversely, individuals discharged to a community psychiatric setting face a wider variety of power tactics which fragment the individual (e.g., surveillance tactics that isolate corporal and social characteristics) and individualise the regulation (e.g., Individual Care Plans). This fragmentation and individualisation of regulation provides a differing space and opportunity for resistance. In short, individuals in the outpatient setting must take an approach to resistance which reflects the fragmentary, individualised forms of power that they face.

Given this argument, the role of everyday forms of resistance are important elements in power relations. Contra Handler, the study of everyday forms of resistance is not trivializing nor romanticizing of these efforts. In this setting, these forms of resistance are the only realistic strategies available to patients. Therefore, to study everyday forms of resistance is to uncover the minute, ongoing, agonistic workings of power relations where strategies are applied and resisted, new strategies are formulated to counter these acts of resistance, which may also be resisted, and so on. In other words, since governance is never a stable project, resistance, in many shapes and forms, is always possible. Everyday forms of resistance highlight that power is everywhere and that there is no end to power relations. They also highlight that power relations are not a 'zero sum game' where one side of the struggle is viewed as successful and the other side as a failure. Success or failure does not enter into agonistic power relations, as strategies may always be met with counter-strategies. In addition, everyday forms of resistance do not seek to right social wrongs or bring about permanent changes in society. In short, this form of resistance is not finite, binary, or normative. Rather, these resistance strategies are undertaken by individuals in an attempt to improve their immediate circumstances through direct and tangible acts which oppose the strategies of power which seek to govern them.

As the present r esearch shows, everyday forms of resistance are an important element of the power relationship. Indeed, resistance, non-compliance or opposition are common features of daily life for nearly all individuals, criminally insane or not. Everyday forms of resistance – from tax evasion, to the use of radar detectors, to falsifying demographic information on the grocery store discount card application – are behaviours that attempt to oppose a wide variety of regulatory strategies. While Handler's critique compels scholars to undertake a more rigorous examination of the effects of everyday forms of resistance, the sheer frequency and ubiquity of this type of resistance renders it an important feature of contemporary society.

Resistance and Capacity

The second important issue highlighted by the study of resistance are the capacities of individuals. Observation of interactions between patients and psychiatric professionals in this setting reveals that patients exhibit active and creative processes (as demonstrated in acts of resistance), which suggests a capacity for action and self governance. Acts of resistance draw attention to the fact that individuals found Not Criminally Responsible are not just passive recipients of psychiatric or legal power strategies, but rather are active participants in power relations. Through acts of resistance, individuals found NCR attempt to establish that they are not solely defined through psychiatric and legal forms of governance. Rather, resistance demonstrates both a desire and capacity to govern the self in a certain manner and to create an identity of one's choosing. "Resistance marks and maintains a zone of autonomy and self-determination that denies the clients' status as dependent" (Gilliom 2005:77). Therefore, resistance is not simply a negation, but rather a creative process. As a creative process, resistance highlights "the ways in which creativity arises out of the situation of human beings engaged in particular relations of force and meaning, and what is made out of the possibilities of that location" (Rose 1999a:279).

In sum, the goal of this study of resistance is to demonstrate that, first, strategies of resistance and strategies of power do not exist in isolation but are conditions of possibility for each other. Second, power strategies are ubiquitous but never infallible. And third, even in situations where power relations are asymmetrical or oppressive, individuals have capacities to resist power tactics and effect change. These capacities are manifest in both the desire to act upon and oppose the limits that govern the individual, as well as in the desire to identify and govern oneself how one sees fit.

Resistance Within the Forensic Psychiatric Outpatient Clinic

This section explores everyday forms of resistance in a forensic psychiatric outpatient clinic from two angles. The first delineates the forms or tactics of resistance in this setting (i.e., What do participants actually do to resist governmental ambitions?). The second part outlines some specific instances of resistance in relation to the broad themes of psychiatric knowledge and psychiatric practice (i.e., What is resisted?). These two perspectives provide the basis for the final section of the chapter which introduces the idea of 'responsibilised resistance' (i.e., the balance that individuals found NCR attempt to strike between resisting tactics of power and demonstrating a responsible self).

Resistance Tactics

Within this research setting, resistance takes many different forms. Resistance tactics range from participants simply refusing to answer questions to more elaborate schemes that involve individuals found NCR avoiding the different strategies of regulation that they face. The different forms of resistance tactics can be divided into two broad and distinct categories. Some tactics of resistance involve direct confrontation between participants where one participant (in this setting, usually the patient) directly opposes the other participant (i.e., the psychiatric professional).These strategies amount to *tactics of refusal*. The other category of resistance involves tactics that avoid direct confrontation between participants. In this category, one participant (most often the patient) develops a strategy that endeavours to elude the attempts to govern his or her conduct. These strategies of resistance may be referred to as *tactics of avoidance*. The following paragraphs describe and provide examples of each of these tactics of resistance.

Tactics of Refusal The first form of resistance I wish to explore is what I call 'refusal'. Quite simply, at the minimum, to resist is to either simply say 'no' or to remain silent in the face of attempts to be governed. Participants in this setting refuse power strategies in many different circumstances. For example, the following two interactions demonstrate simple acts of refusal.

> Nurse: What happened before you were on meds?
> Marie: Not much.
> Nurse: Do you need to take the meds?
> Marie: No.
> ------------------------
> Psychiatrist: How long have you been out of hospital?
> Larry: (Says what month he was discharged.)
> Psychiatrist: Tell Dr. (Forensic Director) what you have been doing (since your discharge).
> Larry: Working.
> Psychiatrist: Can you say more?
> Larry: Not really.
> Psychiatrist: Are you living with (roommate)?
> Larry: Yes.
> Psychiatrist: How's that going?
> Larry: So-so.

In both of these examples, the patients provide minimal or no information to the queries of the psychiatric professionals. In doing so, they are refusing to participate in the psychiatric professional's attempt to collect information that will ultimately be used to govern their behaviour.

Since most of the questions in this setting are asked by the psychiatric professionals, patients have numerous opportunities for this type of refusal. However, on occasion, individuals ask questions of a staff member that are also refused. For example, during a clinical appointment, a staff member asked what the patient did on the weekend. He responded by describing a birthday party he attended for a friend. The patient then asked the staff member when his birthday was, but the staff member simply ignored the question and continued to ask questions of the patient. The individual's question was probably simply an attempt to establish a relationship at a more personal level with the staff member, however, this attempt was rebuffed. It is a small exchange, but one that highlights the power imbalance in this setting. Psychiatric professionals can ignore or refuse to answer questions with impunity, however, patients do so at the risk of being labelled difficult or secretive.

Generally, the tactic of refusal is quite simple and, in most cases, there is little or no counter reaction. Some acts of refusal are met with further queries, at other times the psychiatric professional decides it is not worth the additional effort and lets the issue drop. During my research, I did not encounter many 'grand gestures' of refusal. The following is one of the few examples of such a dramatic occurrence. This interaction took place at a Pre-Board conference. In this example, two psychiatrists, the treating doctor (Dr. Smith) and the Forensic Director (Dr. Jones), question the patient:

> *Joe enters room.*
> Dr. Smith greets him and Joe greets Dr. Smith back and nods a (somewhat suspicious) greeting to Dr. Jones.
> Dr. Smith: How's life treating you?

Joe: OK.
Dr. Smith: Would you like to tell Dr. Jones what you've been doing since you were discharged?
Joe: No.
Dr. Smith: Why?
Joe: I come here all the time and talk.
Dr. Jones: Can you tell me what you do with your time?
Joe: [very defensive and agitated] I tell everyone what I do. I tell (Nurse A), I tell (Nurse B), I tell (Social Worker). I am innocent! You have the wrong man!
Dr. Jones: OK (gives up).
Dr. Smith: How's your feet?
Joe: Not good.
(Short discussion about medical condition and family.)
Dr. Smith: Anything else?
Joe: I've been on the warrant for 7 years - enough! When I was on (the rehab unit), they sent me to (the treatment unit) for no reason…
Dr. Jones: [interrupts] No reason?
Joe: [emphatic] No reason!
Joe: Who said I was Not Criminally Responsible?
Dr. Jones: That would be the judge at your trial.
Joe: What trial? I didn't have a trial.
Dr. Jones: Even so, do you have a mental illness?
Joe: No sir.
Dr. Jones: Do you need to take your medication?
Joe : No sir. I am innocent! You have the wrong man! I have the documentation… [pulling out papers from his jacket pocket].
Dr. Smith interrupts, cuts the conversation off and ends the interview.

Within this relatively short interaction, 'Joe' not only refuses to answer questions and account for himself, he also refuses to acknowledge the legal proceedings that found him Not Criminally Responsible. In addition, he rejects his ascribed status as a mentally ill individual in need of psychiatric medication, as well as his legal status as Not Criminally Responsible. After Joe is dismissed from the room, one of the psychiatrists calls him "delusional", however the other psychiatrist justifies Joe's acts of resistance by stating, "He's fine. He gets anxious at these things", which shifts the characterization of his acts from defiance to a personality flaw.

As Foucault (1997b:168) suggests, to say "no" is the minimum form that resistance can take. By refusing to answer a question or to comply at a basic level, individuals found NCR demonstrate a rudimentary level of resistance in the power relationship. A less obtuse form of refusal occurs when the individual disagrees with the dictates or opinions of the psychiatric professional. The potential areas of disagreement between psychiatric professionals and patients are numerous. Most disagreements revolve around the use of psychiatric medications, the mental illness label or the conditions imposed by the Board of Review. The following is a typical example of disagreement regarding illness:

> Psychiatrist: Do you think (the medication) helps you with your illness?
> Doug: I don't have an illness.
> Psychiatrist: If off the warrant, would you take meds?
> Doug: Yes.
> Psychiatrist: (surprised) Why?
> Doug: To stay on AISH (Assured Income for the Severely Handicapped).

In this example, the patient disagrees with the psychiatric label imposed upon him, but, for strategic (i.e., financial) reasons agrees to continue to take medications.

On occasion, individuals found NCR face accusations by psychiatric professionals that they have disobeyed the conditions the Board of Review has placed upon them or other rules that they must follow. A common response by patients is to deny these accusations. The following interaction demonstrates an example of accusation and denial:

> Nurse: I heard that some guy asked you to go out to a bar.
> Ann: That's not true! Who told you that?
> Nurse: I won't say. It's a confidential source.

> Ann: I'm doing well - my urine is clear.
> Nurse: It's important to stay away from the bars.
> Ann: I never would go.
> *[After the appointment, the patient was heard scolding another patient in the waiting room about sharing secrets with the staff members.]*

This particular act of denial resists both the nurse's accusation as well as the nurse's attempt to govern the actions of the patient. It highlights not only the patient's ability to resist strategies of governance, but also her strategic awareness of refusal mechanisms and types of knowledge (e.g., surveillance techniques) that can be marshalled to reinforce tactics of resistance.

In sum, tactics of refusal, either refusing to cooperate, disagreeing or denying, demonstrate active engagement in power relations. These tactics engage a direct confrontation between participants. While strong tactics of refusal, especially of the magnitude demonstrated above by 'Joe', are relatively uncommon, simple tactics are quite common. The response to these acts are varied. Some are ignored, or sometimes counter strategies are implemented. What often occurs is a continuing series of 'agonistic' interactions. Acts of refusal may be seen by mental health professionals as signs of mental illness, lack of insight, stubbornness, or even as a sign of improved mental health. While most instances of refusal are relatively straightforward and in the open, other tactics of resistance are more surreptitious.

Tactics of Avoidance The other basic strategy of resistance is 'avoidance'. Tactics of avoidance seek to circumvent direct interaction or confrontation between participants. Avoidance strategies also can take many forms. For example, individuals found Not Criminally Responsible may avoid the strategies of regulation of psychiatric professionals by concealing or not sharing relevant information with staff members, or by simply not showing up for a scheduled appointment. However, this latter tactic usually prompts psychiatric professionals to counter with other strategies, such as telephoning patients to inquire why they did not show up for the appointment, or going to the patient's home for an unscheduled home visit.

Another common tactic is to try to avoid answering a question by simply attempting to change the topic of conversation. The following example illustrates this tactic:

> Nurse: Do you know why you are on the warrant?
> Rick: I committed a crime.
> Nurse: What else?
> Rick: (pause) I'd like to go to a football game next year.
> Nurse: You should talk to (Recreation Therapist) about that.
> Nurse: Let's get back to the warrant. You've never spent time in jail.
> Rick: No, never.

During the course of this conversation, 'Rick' attempted several times to divert the topic of conversation from matters of his legal or mental health condition to other subjects. It is well known by staff that Rick is reluctant to answer questions or share information, but this is generally seen as a symptom of a mental disorder rather than a tactic of resistance.

Other avoidance strategies are more complex. For example, it appears that patients observe the routines of the clinic and note when certain activities regularly take place. As discussed in the surveillance chapter, one patient noticed that urine samples were regularly collected on Tuesdays. Therefore, this patient altered his consumption of street drugs so as to avoid being detected on that day.

When staff suspected that this was occurring, they responded by arranging to collect the urine samples on a Thursday.

Another form of avoidance might be called the *switching* tactic of resistance. A classic example of switching in this setting involves avoiding the detection of illegal drug consumption by switching one's urine sample with another drug-free sample. To accomplish this task, a patient must convince a friend who is willing and able to provide a drug-free urine sample. The patient will conceal this clean sample and present it to staff in place of his or her own, presumably, tainted urine sample thereby avoiding the detection of drug consumption.

A similar tactic is *ignoring* power techniques. This strategy might be as simple as a patient outwardly agreeing with the directives of the psychiatric professionals, but secretly having no intention of following these dictates. For example, a patient may receive a prescription for psychiatric medication, fill the prescription, but deliberately not take the medication. In the situation where it is suspected that a patient is not taking prescribed medications on their own, psychiatric professionals will put into place alternative strategies, such as requiring that the patient take the medication in full view of a staff member or a group home worker. On occasion, patients will further resist these strategies by 'cheeking' the medications (i.e., hiding the medication in their cheek and then spitting it out later).

Other ignoring tactics may be more involved. For example, during one case conference, staff discussed a patient who likely left the city without permission. One of the conditions placed on this patient is that he must request permission from the Board of Review to travel outside the city. The patient requested to visit friends in a nearby city, but the request was denied. Shortly thereafter, the patient seemed to disappear for a couple of days – staff members could not reach him by phone and he was not home when a staff member called on his house for a home visit. When the individual re-appeared a couple days later, he maintained that he was in the city, but out of his house when staff members tried to contact him. The psychiatric professionals suspect that he ignored the Board's condition and surreptitiously travelled outside the city to visit his friends. With the tactic of ignoring power strategies, individuals appear to comply with the psychiatric strategies of power, but in reality are resisting them. As demonstrated in this example, strategies of power and strategies of resistance involve a series of organizational and/or interpersonal moves and counter-moves.

In sum, tactics of avoidance are methods of resistance that oppose forms of regulation through clandestine methods. They do not directly provoke a confrontation between participants, but rather seek to alleviate the resisting individual's circumstances without drawing attention to the act of resistance itself. By definition, tactics of avoidance are successful until they are detected. When detected, the most common response by the psychiatric professionals is to confront the resisting individual about the act of resistance and/or to develop a counter-strategy to circumvent the tactic of avoidance. At this point, the resisting individual may convert to a tactic of refusal, as described above, develop a new tactic of avoidance, or may choose to abandon all acts of resistance and comply with the psychiatric forms of regulation. Psychiatric professionals interpret tactics of avoidance in a variety of ways. These acts may be considered as a sign of mental illness, or an indicator of some sort of deviance that requires continued or increased surveillance. Tactics of avoidance by patients may even be admired by staff for the often creative schemes that are developed to resist psychiatric regulation, and staff members even occasionally appear to enjoy the 'agonistic' interplay and counter-strategies that usually follow the detection of acts of avoidance.

Here, tactics of resistance are as varied as the tactics of power. Strategies of power and strategies of resistance interact in a reciprocal fashion. Strategies of power prompt strategies of resistance and, likewise, strategies of resistance prompt strategies of power. In the forensic psychiatric outpatient setting, individuals found Not Criminally Responsible oppose forms of regulations that attempt to govern their conduct, and psychiatric professionals counter these attempts by formulating alternative forms of governance.

This highlights that governance is never a stable project. Neither the tactics of governance nor the tactics of resistance are ever totally successful or completely effective. Strategies of governance and strategies of resistance are continually challenged and subsequently undergo continual refinement. As new tactics of power are brought into operation, new tactics of resistance are implemented, and visa-versa. For example, technology can be utilised by both psychiatric professionals and patients. A staff member might telephone a patient to check if he or she is at home, but the patient might 'call forward' their telephone line to a cell phone and thus receive the phone call when they are not actually at home. Similarly, psychiatric professionals might utilise urinalysis in the detection of illegal drug consumption, but individuals might subvert these drug tests by consuming products that chemically mask the markers of drug use (see Moore and Haggerty 2001).

Within the outpatient setting, there are innumerable initiatives designed to govern conduct and also to oppose this governance. The agonistic relationship between power and resistance is particularly relevant in the outpatient setting where the actual amount of face-to-face interaction between psychiatric professionals and patients is less frequent as compared to the inpatient setting, but where a wider variety of interactions are possible. In other words, compared to the inpatient setting, the outpatient setting provides less frequent contact between patients and psychiatric professionals, but, at the same time, provides for a greater diversity of interactions. This diversity, in turn, provides for greater variety of both strategies of power and strategies of resistance.

What is Resisted?

The preceding discussion of the tactics of resistance highlights that power relations are not fixed, permanent nor stable. Opportunities for power and resistance strategies are numerous and occur in relation to many different subject areas. This section of the chapter broadly clusters the more common themes of resistance. Three main themes of resistance emerge through this process: 1) Resistance to psychiatric knowledge/expertise; 2) Resistance to psychiatric practices; 3) Resistance to identity formation. While each theme is discussed separately, in reality, every power relation is infused with elements related to each theme.

Resistance to Psychiatric Knowledge/Expertise

Psychiatric knowledge or expertise is the body of knowledge that informs psychiatric professionals in their day-to-day dealings with individuals implicated in the psychiatric system. Psychiatric knowledge and expertise provides the basis upon which psychiatrists diagnose and classify individuals. However, as Bauman (1991:2-3) states, "the insufficiency of a classification system produces resistance". Individuals labelled as mentally ill often disagree with the classifications imposed upon them. Opposition to psychiatric knowledge/expertise is attempted by some individuals found Not Criminally Responsible. However, opposition to psychiatric expertise comes with perils. Provisions in the *Criminal Code of Canada* create a situation where resistance to psychiatric expertise is possible, but can potentially work against the individual found Not Criminally Responsible. Therefore, it is a category of resistance that only a few individuals are willing to chance.

As outlined in the *Criminal Code of Canada* (s. 672.54), following a verdict of Not Criminally Responsible on Account of Mental Disorder, the case is referred to a provincial Board of Review who must make one of three possible dispositions regarding the individual found NCR. The usual course of action taken by the Board in Alberta is to initially detain individuals found NCR in a psychiatric hospital, then subsequently discharge them to the community, and eventually, in most cases, grant an absolute discharge. Therefore, virtually all individuals found NCR will have contact with psychiatric professionals, usually in both inpatient and outpatient settings. However, the *Criminal Code* (s. 672.55 (1)) also states that a Board of Review *cannot* direct any psychiatric or other treatment be carried out against the patient unless the individual consents to the treatment.

This latter section of the *Criminal Code* creates a situation where individuals who are found Not Criminally Responsible become involved in a psychiatric setting, but they do not have to consent to psychiatric treatment. In this situation, some patients both refuse to acknowledge and directly oppose the psychiatric expertise that labels them mentally ill and attempts to treat this illness. In short, these individuals refuse to consent to psychiatric treatment. While psychiatric professionals cannot force individuals found NCR to consent to treatment, it is unlikely that these psychiatric professionals would look favourably at this type of behaviour when called to testify at the annual Board of Review hearing for the patient. For example, it is very unlikely that a psychiatrist would support the discharge of an inpatient to the community unless the patient acknowledges the psychiatric expertise that defines the person as mentally ill and also accepts psychiatric treatment. Therefore, most individuals found NCR who initially resist psychiatric expertise and practices eventually realize that in order to progress through the NCR system (i.e., move from inpatient confinement to community discharge to absolute discharge) they must (at least outwardly) acknowledge psychiatric expertise and consent to treatment.

Given this situation, direct and overt resistance to psychiatric expertise by individuals found NCR is rare. The example given above of 'Joe' is one of the few examples of a strong resistance to psychiatric expertise. Recall that Joe refused not only psychiatric expertise but also the judicial system that labelled him Not Criminally Responsible:

> Joe: Who said I was Not Criminally Responsible?
> Dr. Jones: That would be the judge at your trial.
> Joe: What trial? I didn't have a trial.
> Dr. Jones: Even so, do you have a mental illness?
> Joe: No sir.
> Dr. Jones: Do you need to take your medication?
> Joe: No sir. I am innocent! You have the wrong man! I have the documentation… [pulling out papers from his jacket pocket].

The following interaction illustrates another example of resistance to psychiatric expertise. In this example, 'Richard' concedes that psychiatric medications may have some benefit, but, when given the opportunity, reveals his opposition to the psychiatric system. This interaction took place at a Pre-Board conference:

> Psychiatrist: What is the purpose in taking your meds?
> Richard: Helps me not lose my temper, especially with politicians.
> Psychiatrist: Do you have a psychiatric condition?
> Richard: No.
> Psychiatrist: Why do you say that? You have been in and out of the hospital for many years. You have been seen by several psychiatrists.
> Richard: It's your training - atheist training. It is an atheist system.

Richard then proceeded to deliver an articulate treatise on the tribulations and dangers of psychiatry, which seemed to be heavily influenced by academic anti-psychiatry discourses. In evoking this alternative discourse, this individual resists the forms of knowledge that both objectify and subjectify him. However, not surprisingly, this overt opposition works against Richard in that the psychiatric professionals see his statements and beliefs regarding psychiatry as a sign of mental illness and as indicators that he would discontinue his treatment if granted an absolute discharge. After Richard was dismissed from the conference room, the psychiatric professionals discussed what recommendations they would make to the Board of Review at the upcoming hearing. It was unanimous that Richard should not be granted an absolute discharge and that the conditions of his warrant should remain the same (i.e., discharge to the community, regular attendance at the clinic, etc.). The psychiatrist asked the other staff members for justification for this decision:

> Psychiatrist: Why no change?
> Nurse 1: He won't follow up.
> Nurse 2: Will stop completely.
> Psychiatrist: But is he dangerous?
> (Silence - no one answers the question.)

This interaction demonstrates that Richard knows that he must comply with psychiatric treatment (i.e., take prescribed medication) in order to move through the NCR system. However, Richard's resistance to psychiatric expertise is taken by the psychiatric professionals as an indication that he would not comply with psychiatric treatment if absolutely discharged. However, it appears that the psychiatric professionals are not as certain that Richard's opposition to psychiatric expertise renders him a danger to others.

Very few individuals explicitly oppose judicial and psychiatric expertise to the degree that Joe and Richard exhibit. Some instances of resistance are not aimed directly at the psychiatric profession itself, but rather at the forms of knowledge applied by these professionals. For example, psychiatric professionals emphasize that a ubiquitous characteristic of mental illness is that the illness and its subsequent treatment must be considered as lifelong issues for patients. In the following interaction, the patient agrees that he has a mental illness (or knows that he must say that he has a mental illness), but believes that he can overcome this affliction:

> Nurse: Do you have an illness?
> Jerry: The doctor says I do, and I'd agree, but I can get over it.
> Nurse: So you are saying that you don't have an mental illness?
> Jerry: No, I'm saying that I can get over it.
> Nurse: Are you cured?
> Jerry: Not yet.
> Nurse: So you need treatment?
> Jerry: Yes.
> Nurse: What does treatment mean?
> Jerry: Taking meds, seeing someone here.

The resistance to psychiatric expertise in this example is more subtle than in the previous examples. While the patient acknowledges an illness and complies with his treatment plan, his underlying belief is that, eventually and contrary to psychiatric expectations, treatment will no longer be necessary. 'Jerry's' suggestion that he "can get over" his mental illness raises concern with psychiatric professionals about his acceptance of his mental illness and prompts the nurse to explore whether he is actively resisting his treatment regimen.

These examples show the agonistic relationship between psychiatric professionals and individuals found Not Criminally Responsible. Interactions in this setting often involve a strategic interchange where psychiatric professionals provide the opportunity for patients to resist psychiatric expertise by asking potentially provoking questions (e.g., "Do you have an illness?"; "Do you need to take your medications?"). In return, some patients respond by challenging the forms of psychiatric expertise imposed upon them (e.g., "I'm not mentally ill"; "I don't think I'm sick anymore"; "I don't need medications"). The result is an exchange where psychiatric professionals attempt to establish a particular identity in patients, and these individuals attempt to resist or avoid the forms of regulation and/or stigma associated with these identities.

Opposition to psychiatric expertise represents a higher order level of resistance. This strategy requires a level of adeptness that few individuals are willing or able to marshal. Rather than resisting the heart of the profession (i.e., psychiatric expertise), most resistance in this setting is aimed at 'everyday' psychiatric practices. Therefore, these forms of resistance can be more typically described as 'everyday acts of resistance'. The following section provides some examples of such practices.

Resistance to Psychiatric Practices

This section examines occurrences of resistance in relation to some common psychiatric practices. Procedures utilised by psychiatric professionals' may include a wide range of clinical and non-clinical routines, and formal and informal activities. This discussion will not provide an exhaustive list of all types of psychiatric practices and activities. Rather, it focuses on acts of resistance in relation to common types of clinical procedures (i.e., the use of medication and psychotherapy) and non-clinical psychiatric activities (i.e., surveillance, risk identification and management). While some individuals found NCR may resist all psychiatric practices and activities, others may only resist a selection of these routines.

Resistance to Clinical Psychiatric Practices Possibly, the most common category of resistance within the forensic psychiatric outpatient setting revolves around the recommendation and application of psychiatric treatments. As described above, individuals found Not Criminally Responsible do not have to consent to treatment, however most eventually acquiesce to treatment in order to be seen in a favourable light when they appear at their annual Board of Review meeting. Nevertheless, there are also many instances of resistance to psychiatric treatment.

The use of prescription psychiatric medications and psychotherapy are the two main forms of psychiatric treatment prevalent in this setting. Virtually all individuals found Not Criminally Responsible are prescribed psychiatric medications, while only some patients are both prescribed medications and referred for psychotherapy. The following descriptions provide examples of resistance to both types of psychiatric treatment.

Resistance to Psychiatric Medications Many individuals feel that psychiatric medications produce objectionable effects, such as a dulling effect, impotence, or constipation. Consequently, there is a constant struggle between these patients and the psychiatric professionals over issues concerning medications. For example, disagreements commonly emerge over the dosage of medication, as the following two examples illustrate:

> Nurse: I'd like to see all of this (list of goals written on the board) and for you to continue on medications.
> Jeff: For sure, that's a life long thing. Although, I'd like to reduce it.
> Psychiatrist: Don't push it (laughs).
> ------------------------------

Nurse: How's the meds working? Too much? Too little?
Brian: I'm restless. I toss in bed - can't sleep.
Nurse: How many (side effects meds) do you take?
Brian: One a day.
Nurse: Why don't you take two instead tonight.
Brian: I don't like screwing with my meds.
Nurse: Then how about taking it later in the evening - at 9:30. Try it tonight. Then phone me tomorrow.
Brian: (no response)

These two examples illustrate very common exchanges between patients and staff involving the amount of medication that is prescribed. Many interactions between patients and staff in this setting revolve around attempts by patients to reduce the amount of medication they are prescribed or attempts by psychiatric professionals to persuade patients to comply with an increase or modification of the prescription.

The dosage of the prescription is not the only area of resistance involving medications. Some individuals found NCR resist the types of medication they are prescribed. For example:

Psychiatrist: Do you think the meds help you?
Sarah: I'm not sure about the anti-psychotic, but the anti-depressants are OK.

Some patients may feel that they do not require certain types of medications or are troubled by side effects from certain medications. In these circumstances, many individuals found NCR challenge the use of these medications in their treatment regimen. Similarly, some patients, like the individual in the following example, question the necessity of continuing to take prescribed medications.

Dr: What do the meds do for you?
Bill: Makes the symptoms go away.

> Dr: What would happen if you stopped the meds?
> Bill: Seriously, I think I would be OK. I don't want to hurt anyone, violence scares me.

Other individuals assert that the prescribed medications have had a detrimental effect.

> Dr: Do the meds help?
> Jack: I got to take them, that's all.
> Dr: So they don't help?
> Jack: I was smarter before I took them.
> Dr: Smarter?
> Jack: There is a difference. There was one week I was crazy, but I was smarter (then).

These exchanges amount to a struggle between patients attempting to control the amount or type of potentially mind-altering or side-effect-producing medications that they consume versus psychiatric professionals attempting to regulate behaviour through the use of psychiatric medication.

The practice of prescribing medications and the various forms of resistance to this practice are clear examples of the agonistic interactions that occur in this setting. Psychiatric professionals encourage patients to first acknowledge the need for psychiatric medications and encourage patients to consent to taking the drugs. As discussed above, most individuals found NCR realize that in order to progress through the system they must consent to this form of regulation. However, everyday forms of resistance to this psychiatric practice are evident. Some patients may report that they are taking the prescribed medication, but in reality are not. Other patients may resist the type or amount of medications they are prescribed. Some patients may report side-effects of the medications that do not occur in order to prompt a reduction in the medication, while still others may purposely not report side-effects or other symptoms in order to avoid any modification in their prescription. Ultimately, the prescription of psychiatric medications produces a curious power relationship. On one hand, most individuals found NCR realize that they must comply with this requirement, often against their wishes. On the other hand, psychiatric professionals must rely on the patients to provide information on the results or effectiveness of the medication. As discussed in Chapter Five, patient insight has become a necessary, but not always trusted, element in governing criminal insanity. Therefore, the patient may resist this form of regulation through the content of the self-reports they provide to the psychiatric professionals.

Resistance to Psychotherapy While the use of psychiatric medications is the primary form of treatment in this setting, the use of psychotherapy is also practiced with some patients. Two forms of psychotherapy, group therapy and family therapy, are commonly utilised. Resistance or opposition to the necessity or usefulness of psychotherapy represents another site of everyday resistance.

Psychiatric professionals often strongly encourage individuals found NCR to join ongoing therapy groups. The following interaction, which took place at an Individual Care Plan meeting, demonstrates how several members of the treatment team attempt to persuade a patient to consider joining a therapy group:

> Nurse: We have about 4-5 people we work with who have stopped going back to hospital [implying successful group therapy patients]. You interested?
> Max: Sure [reluctant], but I'm not sure it's for me.
> Psychologist: I'd like you to think about joining the group. It's every second Thursday. It's something to think about.
> Max: OK.
> Psychiatrist: You seem to be socially isolated. Do you agree?

> Max: Not really. I have friends, but I don't like talking to strangers.
> Psychologist: (Describes what happens in the group). You don't have to talk. Some people have come to group and don't say anything for 2-3 sessions. It can be very supportive to talk to people who are going through the same thing as you.
> Psychiatrist: What is it that you don't like about groups?
> Max: I don't like being the center of attention - talking about myself.

In the preceding example, 'Max' resists attending the therapy group because he believes that he would feel uncomfortable participating in this type of social setting. In the following example, which also took place at an Individual Care Plan meeting, the treatment team attempts to persuade 'Jeff' to join a therapy group. Previous to this meeting, Jeff had been approached several times by staff members to join the therapy group, but had rebuffed them on each occasion because he believes that he does not need this type of treatment. At the Individual Care Plan meeting, while discussing his desire to increase his knowledge about his mental illness, the psychiatric professionals attempt once again to encourage Jeff to attend the psychotherapy group:

> Psychologist: You said that you would like to know more about your illness.
> Jeff: Yeah (remembering), I'd like to learn more.
> Nurse: We could answer your questions about meds.
> Jeff: (taking the opportunity) Is it true that we don't know how (medication name) works?
> [General consensus among treatment team that that is true.]
> Nurse: It just does, we don't know how.
> Psychiatrist: Do you know enough about yourself?
> Jeff: Oh, yeah.
> Psychiatrist: But I'd like you to keep it up.
> Psychologist: I'd like you to be more courageous.
> Jeff: (Sitting up) I've got courage!
> Psychologist: I mean trying new things. I'm thinking of the (therapy) group.
> Jeff: I'm not scared of the group.
> Nurse: The group is a great place to learn about your illness.
> Jeff: (Slouching back down in his chair) You've got me there.

In this interaction, the psychiatric professionals strategically guide the discussion towards the goal of getting Jeff to attend the therapy group. After getting him to state that he would like to learn more about his mental illness, and answering some of his questions, the treatment team leads Jeff to acknowledge that group therapy would help him secure this goal. Despite this concession, Jeff ultimately did not attend any group therapy sessions.

On certain occasions, family members of individuals found NCR are invited to attend therapy sessions. While most family members (usually parents of the patient) agree to participate in this type of psychotherapy, on occasion, family members also resist this type of psychiatric treatment. For example, despite a number of invitations to attend family therapy sessions, the family members of one patient consistently decline or fail to attend. The psychiatric professionals surmise that the family is reluctant to come because they have a long history of unsuccessful dealings with mental health professionals. At the team meeting held before the Individual Care Plan meeting, the treatment team discusses the patient's situation:

> Psychiatrist: Family might have had therapy already with (previous institutional facility). Maybe that's why they are resistant to family therapy (here).
> Nurse: Once they get to know us, they'll love us (laughs).
> (Patient's extensive history of institutional contacts is read from report.)
> Therapist: You can see why the parents are burnt out. Maybe they have been coming to these kind of meetings for a long time now.
> Psychiatrist: I wonder if the parents are waiting for us to fix the problem.
> Nurse: They have to become involved.

At the Individual Care Plan meeting, the psychiatrist asks the patient about his family's reluctance to attend family therapy sessions:

> Psychiatrist: Does your family understand your illness?
> Gerald: No.
> Psychiatrist: Why?
> Gerald: They don't like that I'm sick. We don't talk about it at all.
> Psychiatrist: Do you think that's why your mom didn't come today?
> Gerald: She had other things she had to do.
> Psychiatrist: Do you think that she doesn't want to come because she is uncomfortable talking about this.
> Gerald: Maybe (near tears).
> (Psychiatrist expresses a wish that Gerald's family become more involved.)
> Psychiatrist: We are the experts in your mental health problem, but they are the experts on you.

While patients are not held responsible for family members who decline to participate in family therapy, it is generally believed by the psychiatric professionals that family therapy improves the mental health of patients. Therefore, patients who, it is believed, would benefit from family therapy but do not receive it are considered to be lacking in their treatment regimen. This form of 'family member' resistance negatively impacts the patient, but is an issue of non-compliance that the person has little control over.

Ultimately, within the outpatient setting, individuals found Not Criminally Responsible must comply with the treatment regime or risk being seen by the psychiatric professionals as 'non-compliant' and/or 'lacking insight', which consequently is thought to place them at greater risk of danger to themselves or others. Individuals regarded in this manner would not receive a favourable report by the treating psychiatrist at the annual Board of Review meeting. Such an occurrence would almost certainly prevent the Board from granting an absolute discharge to the patient. In fact, it could indeed lead the Board to re-admit the individual to the inpatient facility.

Despite the highly asymmetrical relationship, there is a ubiquitous give and take between psychiatric professionals and individuals found NCR. There is a constant attempt to apply 'everyday psychiatric practices' by staff members and a constant 'everyday resistance' to these practices by patients. The use of prescription medication and psychotherapy are the most common forms of psychiatric practice used to regulate individuals diagnosed with mental illnesses. Consequently, resistance to psychiatric treatment represents a salient method by which individuals found Not Criminally Responsible can oppose this regulation and attempt to govern themselves in ways they see fit.

Resistance to Non-Clinical Psychiatric Practices

Other psychiatric practices are less directly related to treatment issues. Surveillance tactics and risk assessment and management comprise common non-clinical activities carried out by psychiatric professionals. While not directly related to treatment issues, these activities represent power strategies that play a significant role in the regulation of individuals found Not Criminally Responsible. The following paragraphs provide examples of resistance to these non-clinical psychiatric practices.

Resistance to Surveillance Tactics As discussed in Chapter Five, the purpose of surveillance is to visualize particular entities or problems. In the outpatient psychiatric setting, surveillance focuses primarily on corporal features (e.g., the body, urine, blood) and social features (e.g., demeanour, social relationships) of individuals found Not Criminally Responsible. Psychiatric professionals rely on various techniques in order to render criminal insanity visible, including technical procedures (e.g., urine and blood analysis), direct observation of the individual, as well as relying on the individual to reveal the results of self surveillance.

Like other power relations, practices of surveillance utilised by psychiatric professionals are often resisted by patients. However, as in Gilliom's (2001) study of welfare recipients, most individuals in this setting do not complain that surveillance tactics invades their privacy or attempt to avoid surveillance to maintain their privacy. It is possible that the constant surveillance that these individuals undergo renders them accustomed (or resigned) to the near constant invasion of privacy. Or, more likely, individuals found NCR realise that overt resistance to surveillance tactics will likely result in increased surveillance, rather than an increase in privacy. Therefore, most individuals in this setting resist surveillance in ways that do not bring direct attention to their non-compliance.[2]

When resisting acts of surveillance, most individuals found NCR do not engage in tactics of refusal. To explicitly refuse to answer a question or provide a urine or blood sample, for example, would not only raise the suspicions of staff members, but would also likely reflect poorly on the individual at the next Board of Review hearing. Rather, tactics of avoidance are much more common. For example, forms of surveillance that focus on corporal features can be avoided by the patient by simply not showing up for or postponing the appointment at the clinic. Other forms of resistance to surveillance of corporal features, as discussed above, include switching one's tainted urine sample with another person's clean sample or consuming products that mask one's illicit drug use.

Not showing up for a scheduled appointment is the simplest and most common method of avoiding surveillance. However, a patient who consistently misses appointments will elicit additional forms of scrutiny. For example, one patient consistently states that he simply forgets to attend his scheduled appointments, but will show up at the clinic unexpected – usually at the end of the day when his primary therapist has other appointments scheduled or when urine and blood samples are generally not collected. At a weekly case conference, staff debate whether he is doing this on purpose, or if his mental illness or the prescribed medications are impairing his memory. Staff then debate what measures should be taken to deal with his behaviour. For example, they discuss implementing a more rigid appointment schedule where the patient must attend appointments more frequently; staff consider regularly telephoning the patient to check on him and to remind him of the upcoming appointments; the psychiatrist suggests taking blood samples which might determine if his medication is causing unwanted side effects; and finally, staff discuss altering the dosage and type of psychiatric medications the patient is prescribed which would then necessitate further monitoring, either through more frequent appointments, home visits, or blood testing. Therefore, by resisting surveillance through missed appointments, the patient faces additional forms of governance and surveillance. Of course, the patient may chose to resist these newly implemented surveillance strategies as well.

The surveillance of social features of individuals found Not Criminally Responsible is generally accomplished through direct questioning of the patient.

Patients are asked about their family, work, living arrangements, and so on, and are expected to respond to these inquiries. Again, to simply refuse to answer these questions would not be in the patient's best interests. Rather, resistance takes more subtle or clandestine forms. When faced with questions from a psychiatric professional, the simplest, and possibly most effective, form of resistance is for the patient to conceal or mask the information they do not wish to share – in other words, to lie, stretch the truth, or make up answers. Patients may be deceitful about family relations, work opportunities, alcohol/drug consumption, or virtually any other topic that is questioned. If the psychiatric professional is satisfied with the answer provided by the patient, then the tactic of resistance is successful and personal matters remain concealed. On the other hand, if the psychiatric professional is doubtful of the veracity of the answer provided by the patient, other strategies may be put into play. These other strategies may include additional, more intense questioning of the patient, and/or contacting other individuals (e.g., family members, employers) to discover alternative answers to the question. The psychiatric professional will also discuss his or her suspicions of the truthfulness of the patient's statements with other staff members at the weekly case conference. This would result in all staff members questioning the patient in subsequent appointments about the topic in question. Once again, tactics of resistance are often met with further strategies of governance, which may, in turn, be met with additional tactics of resistance.

Resistance to Risk Assessment The identification and management of risk factors is another strategy in governing criminal insanity. Within this setting, risk factors are identified through a combination of clinical and actuarial methods. As discussed in Chapter Six, clinical risk identification is based on disciplinary forms of knowledge – case records, clinical judgement, etc. – that translates expertise into predictions regarding individual actions. Actuarial risk identification focuses on the use of questionnaires or risk assessment tools that use quantitative or statistical calculations of variables gathered from a population to predict the future actions of the individual in question.

In the forensic psychiatric outpatient setting, one of the main tasks of psychiatric professionals is to be constantly vigilant for factors that might be predictive of problematic behaviour. Clinical risk identification and management requires that the psychiatric professional interact with the patient in order to establish, first, factors that may be considered 'risky' for that individual and, second, a strategy to minimise the risk that these factors bring about. Like other psychiatric practices, risk assessment practices are power relations that may be resisted by patients. Psychiatric professionals utilise surveillance techniques to identify risk factors that may predict a relapse in mental illness or re-offence. For example, a blood or urine sample that produces abnormal results may indicate to the psychiatric staff that the patient is at risk for relapse. Similarly, psychiatric professionals attempt to make visible social features of the patients that might be predictive of relapse or re-offence. A patient who describes a social situation that is considered by staff to be problematic may be considered to be a risk. Therefore, non-compliance with surveillance techniques by patients directly results in resistance to clinical risk assessment procedures.

To illustrate, psychiatric professionals consider alcohol or drug consumption to be a significant risk factor for a relapse in mental illness. In the following example, just prior to this interaction, "Tony" admitted to a staff nurse that he regularly smokes marijuana.

> Nurse: You don't believe that when you were smoking up that it will affect your voices? Make it worse.
> Tony: It makes it better. It relaxes me for a few hours and then the voices come back.
> Nurse: So how do you feel when it (marijuana) wears off?
> Tony: Good. It makes the voices go away for a while.
> Nurse: If I told you that the (name of medication) and the joint together will make you worse, which will you give up?
> Tony: (not convincingly) The joint.
> Nurse: So we have to help you give up the drugs.

This interaction demonstrates an agonistic interaction where the nurse identifies the consumption of marijuana as a risk factor for relapse and the patient resists this view stating that, to the contrary, smoking marijuana diminishes his symptoms, in effect reducing the risk of relapse. After repeated warnings from staff to abstain from smoking marijuana, and repeated promises to quit, a urine analysis was eventually carried out (which tested positive for marijuana) and 'Tony' was re-admitted to the inpatient facility.

In sum, risk factors are identified through techniques of surveillance. That is, by making visible certain corporal or social features of the individual, factors or behaviours are identified that may be interpreted by psychiatric professionals as putting the patient 'at risk' for relapse or re-offence. Therefore, by resisting tactics of surveillance, individuals found NCR are also resisting clinical risk identification.[3]

Resistance and Identity Formation

Psychiatric practices create identities for the individuals implicated within the system. Forensic psychiatry reproduces and relies upon identities such as: patient, mentally ill, criminally insane, irresponsible, addicted, and the like. However, the individual to whom these labels are applied may resist these identities and attempt to establish alternative identities – e.g., someone who's getting better, a recovering addict, a non-violent person, and so on. Therefore, while the labels applied by psychiatric professionals can, on one hand, be stigmatizing, on the other hand, the application of labels can also produce opportunities for resistance. The following analysis describes the interplay between the formation of identities and resistance strategies.

Resisting Labels Labels imposed upon individuals within this setting are essentially psychiatric 'shorthand' used by staff to describe some general features or characteristics of a patient. There are several common identities that are applied within this setting. Some labels, such as 'delusional' 'manic' or 'depressed', are associated with specific behaviour and specific diagnoses. Other labels, like 'crazy', 'mad' or 'immature', are associated more generally with behaviour staff view as irrational. Patients who resist psychiatric treatment or advice are labelled 'insightless' or 'non-compliant'. Finally, individuals who avoid any of the previous identities may be labelled as 'ideal' patients.

Identities are used to parsimoniously convey information between professionals. For example, to convey that a patient's current psychiatric status is the same as their previous or usual status, staff often use the phrase, "Kevin is

Kevin", to indicate that the patient (in this case 'Kevin') is exhibiting his usual behaviour and/or demeanour. In addition, staff will also use the phrase "He's no Kevin" to compare one patient to another. In this case, the patient in question does not exhibit the characteristics of 'Kevin', either for better or for worse in the opinion of the psychiatric professionals. The use of these phrases sets the identity of the individual within certain parameters. To exhibit behaviours or demeanour outside these parameters would be considered abnormal by the psychiatric professionals.

Some patients readily accept the identities imposed upon them, while others resist these identities. For those latter individuals, tactics of refusal are the most common forms of resistance. For example, psychiatric professionals often label patients as 'dangerous', which connotes that the patient presents a threat to themselves and/or others and thus requires additional surveillance and/or treatment. In the following interaction, the patient knows that she has been labelled dangerous and attempts to resist this identity.

> Catherine: Have the Board findings been released?
> Nurse: Yes, didn't you receive them? (opens file, removes the Board ruling and hands it to Catherine.)
> Catherine: (reads all the conditions out loud) No change - nothing.
> Nurse: What were you hoping for?
> Catherine: Absolute discharge. I don't write threatening letters anymore, I don't drink, I don't do drugs, I'm not a threat to myself or anyone else. It's just that (Psychiatrist) thinks I'll go off meds and be a danger (getting a little bit agitated).
> Nurse: Yep.
> Catherine: But I'm not a danger!
> Nurse: I guess we'll have to agree to disagree. How does the (Board ruling) make you feel?
> Catherine: Disappointed, but nothing I can do about it.

Rather than accept the label, this patient directly addresses the specific concerns that would garner the dangerous label – in this case, previous threatening behaviour, alcohol/drug consumption and non-compliance with medications. In this instance, the tactic of refusal is not particularly successful (i.e., the nurse still believes that the patient poses a danger), however, the patient was able to articulate an identity that differs from the one provided by the psychiatric professionals.

Once a label has been applied, it is often difficult for the individual to alter that identity. For example, it is assumed by psychiatric professionals that individuals who have abused substances will continue to do so if given the opportunity, and therefore these individuals should undertake continuous rehabilitation. In the following example, 'Danny' attempts to shift the label of 'addict' that he has been identified with to that of 'recovered addict'.

> Therapist: What have you been doing to maintain abstinence?
> Danny: Attended Henwood[4], gaining knowledge there, also from other addicts who share their stories.
> Therapist: Have you done any follow up sessions?
> Danny: No. They said I didn't have to.
> Psychiatrist: Have you found any other support?
> Danny: At Henwood, they said that some people need weekly meetings and some people who aren't active users don't need weekly meetings.
> Psychiatrist: But they don't know your history.
> Danny: (adamantly) They do! I had to tell them everything. I've had a total overhaul of my life. A total change. I'm not saying I don't need it (addiction programs), just not right now.
> Psychiatrist: I think we'd all encourage you to seek out some group to help you.

'Danny' does not deny that substance abuse was an issue in his life, rather, what he objects to is the *ongoing* label of addict. He attempts to shift the identity of addict and present himself with the identity of someone who has overcome an addiction.

The preceding examples highlight instances of individuals found NCR resisting particular identities. However, not all individuals resist the identities that they are labelled with. Some individuals passively accept and do not resist the identities that are applied to them. Other individuals accept the identity, but use the identity they are labelled with as the basis for resistance. For the latter group of individuals, in other words, instead of resisting the imposed identity, these individuals actively accept the identity and use it to resist practices that attempt to regulate them. For example, individuals may resist taking on additional responsibilities (e.g., looking for employment, moving out of the group home) by claiming that they are "still too sick" or that their mental illness or their psychiatric medications interfere with these tasks. In these cases, individuals use the 'mentally ill' identity to resist strategies of governance that attempt to shape their conduct (e.g., getting a job), or forms of governance that attempt to create an identity (e.g., someone who leads a "normal" life).

In another example, a common practice in clinical appointments is to encourage individuals found NCR to state what additional legal conditions they would like to receive from the Board of Review at their next annual review. The staff then use these goals to govern the individual's behaviour (e.g., "You won't be allowed to leave the city unless you …"). In the following interaction, the individual not only accepts his identity as 'criminally insane' but uses this identity to avoid answering the nurse's question.

> George: I have a Board (meeting) in April.
> Nurse: Yes, they will send you a letter.
> George: Just like usual.
> Nurse: What will you ask for (from the Board)?
> George: (shrugs)
> Nurse: Don't you want to get off the warrant?
> George: I'll never get off the warrant. I've been on for 22 years.

By declining to set what he believes are unattainable goals, 'George' uses his identity as 'criminally insane' to resist the nurse's strategies. From George's perspective, he will never achieve absolute discharge (i.e., he will always be criminally insane), therefore he refuses to provide a set of goals which would become fodder in the attempt to direct his behaviour.

The preceding examples demonstrate that, through everyday forms of resistance, some individuals found Not Criminally Responsible struggle to oppose identities that they are labelled with, and, in contrast, some individuals accept and use these identities to resist psychiatric regulation. Either way, resistance involves the establishment of an identity which is used to resist the application of labels, the comparison to norms, the imposition of forms of 'truth' or the governance of behaviour.

Discussion: Resistance Is Not Futile – Formulating 'Responsibilised Resistance'

The personal costs to patients who resist within the forensic psychiatric outpatient setting can be high. Individuals found Not Criminally Responsible who resist psychiatric expertise and practices may face increased surveillance, re-admission to the inpatient facility, or prolonged involvement in the Board of Review system. Yet, within this setting, resistance is not only common, but anticipated and even expected. For example, psychiatric professionals often deliberately provide opportunities for patients to resist psychiatric regulation or expertise. This is accomplished through questioning the individual on topics that the psychiatric professional knows will be provocative. The individual's response to these opportunities are taken as indicators of the patient's mental health status. Strong resistance or refusal is usually interpreted by psychiatric professionals as a sign of mental illness and/or as a lack of insight. On the other extreme, a complete lack of resistance may also be interpreted as a sign of continuing mental illness and dependence on the psychiatric system. However, somewhere in between these two points – a less vigorous resistance, but still a spirited response – may be interpreted as a progression to good mental health status or may even be interpreted by psychiatric professionals as an indicator of the initial stages of independence from the psychiatric system.

Considering the asymmetrical power relationship between the psychiatric professional and patient, one might be tempted to conclude that resistance within the forensic psychiatric outpatient setting is futile. Single instances of resistance rarely achieve the desired effect[5] (from the patient's point of view) and are usually met with counter-resistance tactics that may further encumber the patient. However, certainly not all instances of resistance are pointless. To the contrary, resistance in this setting is essential. Rather than viewing resistance as a singular event with a solitary goal, acts of resistance should be viewed as a part of an ongoing agonistic relationship. Resistance should not be seen only as a reaction or passive response to a particular power strategy, but as an active dynamic within a power relationship. Within this setting, strategies of governance and strategies of resistance should be seen as a prolonged struggle, involving many different tactics that include numerous singular 'battle fronts'.

Observations of power relations between psychiatric professionals and patients in this setting suggest that individuals found NCR must display a certain amount and a certain kind of resistance in order to be considered for absolute discharge. This mix of subtle non-compliance and prudent behaviour can be called 'responsibilised resistance'. It is not too much resistance, nor too little. It is not resistance of psychiatric expertise or certain practices (i.e., resisting a diagnosis and treatment regimen). Rather, it is a resistance with a demonstration of responsibility, for example:

- Individuals who want to administer their own medications, rather than having them administered to them;
- Individuals who argue to live on their own, rather than in a group home;
- Individuals who resist the identity associated with a certain diagnosis, but show insight into the condition;
- Individuals who maintain that they should be granted an absolute discharge, but say that they will continue to take prescribed medications and see the psychiatrist on a regular basis after the discharge.

The individual found Not Criminally Responsible must not challenge psychiatric expertise or practices too strongly, and, at the same time, must demonstrate the ability to act responsibly and independently. In other words, responsibilised resistance is an active engagement within the power relationship that, on one hand, complies with psychiatric expertise and practices, but, on the other hand, demonstrates a capacity to govern oneself responsibly and independently of psychiatric regulation. When the individual found NCR constructs an identity that strikes the right balance of resistance and responsibility, the individual is much more likely to be considered for absolute discharge by the psychiatric professionals and the Board of Review.

In sum, resistance is an important factor in governing criminal insanity at a forensic psychiatric outpatient clinic. In this setting, individuals found Not Criminally Responsible utilise two basic forms of resistance tactics to oppose psychiatric and legal regulation. The first category can be termed tactics of refusal which involve one participant directly opposing the power strategies of the other participant (e.g., refusing to answer a question). The second category, tactics of avoidance, involve resistance strategies that seek to avoid power tactics or direct confrontation between participants (e.g., changing the topic). Resistance tactics are used by individuals found NCR to oppose forms of psychiatric expertise, various forms of psychiatric practices, as well as the formation or application of various identities. In this setting, single instances of resistance are rarely successful and are often met with counter-resistance strategies, which highlights the agonistic nature of power relations. However, for the individual found NCR, resistance is not futile. In fact, the individual must display a combination of both resistance and responsibility – or 'responsibilised resistance' – before being considered for absolute discharge. To conclude, the study of resistance highlights the intricacies of power relations as well as the capacities of individuals to resist power strategies and effect change in their lives. Everyday forms of resistance mirror advanced liberal modes of governance and speak to the motivation behind the aims and ambitions of those who seek to govern themselves in ways that oppose the forms of regulation that they face.

Chapter Eight – Ethics

The extension of forensic psychiatry to community settings is a manifestation of the shift in modes of governance. When confined to the inpatient facility, criminal insanity is governed through more direct forms of intervention (i.e., disciplinary tactics). Whereas, discharge to the community relies on more indirect forms of intervention which specifically require patients to govern themselves. In other words, criminal insanity is not just regulated through direct forms of psychiatric practice, but increasingly, individuals found Not Criminally Responsible are required to play a role in their own governance.

The three previous chapters focus on direct techniques of governance of criminal insanity. Specifically, the chapter on surveillance illustrates the tactics by which criminal insanity is made visible. The chapter dealing with risk explores how risk is attached to the subject and subsequently managed in unique ways. The chapter on resistance focuses on the forms and responses to resistance within the forensic psychiatric outpatient setting. In short, each of the preceding chapters describes the objectification of the subject through direct forms of regulation and provides an understanding of how the subject is formed, organized and governed. However, in addition to these objectifying forms of governance, another theme pervades each of these chapters: self governance.

For example, in addition to the many ways in which psychiatric professionals make criminal insanity visible, the surveillance chapter also explores how patients must demonstrate 'insight' as a necessary component in making themselves visible. Likewise, the risk chapter explores how individuals found NCR are required to identify and manage their own risk factors. Within the resistance chapter the theme of self governance is even more evident. As posited, before individuals found NCR are considered for absolute discharge, they must demonstrate what is considered by the psychiatric professionals to be the right combination of resistance and responsibility – what I have termed 'responsibilised resistance'. Thus, as the previous chapters have already suggested, within the forensic psychiatric outpatient setting, governing criminal insanity involves a combination of techniques that regulate subjects through passive, objectifying techniques as well as requiring and encouraging subjects to become active in their own governance. These latter strategies suggest new and changing modes of governance for forensic psychiatry. Rather than governing solely through direct techniques, this new mode of governing acts indirectly, seeking to regulate the conduct of others by inducing and encouraging subjects to self govern. In other words, within the forensic psychiatric outpatient setting, self governance becomes a 'designed in' feature in the regulation of criminal insanity.

As described by Foucault, the constitution or transformation of the self, through forms of self governance, is an ethical endeavour. From this perspective, ethics is the concern with the self's relation to itself – "how the individual is supposed to constitute himself as a moral subject of his own actions" (Foucault 1997c:263). This relationship, how we relate to ourselves, involves an "aesthetics of existence" (Foucault 1985:12, 89-93). This chapter considers how individuals found Not Criminally Responsible use techniques of self governance to create an 'ethical self'. The aim is to shift attention from the examination of techniques in the governance of others, to techniques of self governance; in Foucault's terminology, from the objectification to the subjectification of criminal insanity.

This chapter considers how subjectivities are formed through ethical self government. It begins with an examination of what Foucault describes as ethics, specifically what he describes as the four aspects of ethical government. Next, I consider the notion of 'responsibilization' – that is, the ethical endeavour to take responsibility for one's thoughts and actions. The final section examines the 'etho-political' process –whereby psychiatric professionals attempt to influence conduct of patients by acting upon the forces thought to shape the ethical practices of these individuals. Etho-political processes highlight how psychiatric professionals encourage individuals found NCR to act responsibly and, likewise, how patients demonstrate that ability.

Ultimately, the purpose here is to illustrate that responsibility, autonomy and freedom are not simple, pre-given phenomena, or qualities to be discouraged and marginalized within the forensic psychiatric outpatient clinic. Rather, they are created and become the focus of forms of regulation in this setting. Indeed, before individuals found Not Criminally Responsible are granted an absolute discharge, they must demonstrate that they have mastered the techniques of the self. Thus, the main task of psychiatric professionals in the outpatient clinic is to inculcate a particular vision of rationality and responsibility within the patient. Likewise, the main task of the individual found Not Criminally Responsible is to achieve and display a quantum of self governance that is considered rational and responsible.

Ethics and Technologies of the Self

The domain of ethics concerns the self's relation to itself. Following Foucault, ethics is not a set of standards or rules guiding behaviour, but how we form ourselves into subjects or recognize ourselves as subjects. For Foucault, the subject is not simply the passive recipient of governmental technologies of domination, but rather is a contingent product of both techniques of domination (i.e., forms of regulation which objectify the subject) and technologies of the self (i.e., practices undertaken by the subject which shape and regulate the self). Foucault (1997d:225) defines technologies of the self as practices "which permit individuals to effect by their own means, or with the help of others, a certain number of operations on their own bodies and souls, thought, conduct, and way of being, so as to transform themselves in order to attain a certain state of happiness, purity, wisdom, perfection, or immortality". It is the encounter between the technologies of domination of others and the technologies of the self that Foucault calls 'governmentality' (Foucault 1997d:225).

The scholarship of both Foucault and Goffman converge with their theories of the self. For Goffman, like Foucault, there is no essence within the individual waiting to be released, rather, the self is entirely a product of a social performance within a social situation. Goffman is interested in specifically how the self is presented, and how this presentation is influenced by factors such as social position or interactions between participants. Goffman's analyses detail how social actors, interactions and contexts shape the formation of the self. The goal here is to integrate both the perspectives of Foucault and Goffman to understand how particular practices or techniques contribute to the formation of a self and subsequently govern thought and behaviour.

Within the forensic psychiatric outpatient setting patients must portray a particular kind of 'self'. Specifically, individuals found Not Criminally Responsible must present a self that is seen as rational and responsible when viewed through the lens of psychiatric authority and knowledge. The following excerpt provides an example of a typical interaction at a Pre-Board conference between a psychiatrist and an individual found NCR. The line of questioning and the patient's answers draw attention to the process of ethical government of the self.

> Psychiatrist: How long have you been out of hospital?
> Gregg: Three years.
> Psychiatrist: Tell us what you've been up to.
> Gregg: Working. I'm doing quite well. I just finished paying for my house.
> Psychiatrist: What do you do for work?
> Gregg: Engineer. There's good business in Alberta. I'm pretty sound in the financial area. I've been saving for my retirement fund.
> Psychiatrist: What sort of privileges would you like from the board?
> Gregg: I'd like to be able to go up north to work. A longer period of time between visits – maybe two months. Taking a day off to come here throws the schedule off at work.
> Psychiatrist: Looking back to what happened (i.e., the index offence), what's your attitude now?
> Gregg: It was a tragedy. I aspire to be your best patient (everyone chuckles). The medication has been a great help. When I got ill last time, I took the meds and got better in three days.
> Psychiatrist: What would happen if you stopped the meds? Would you stop it?
> Gregg: I have no problems taking it. I have no side effects.
> Psychiatrist: What is your attitude to alcohol now.
> Gregg: I go to AA (Alcoholics Anonymous). I don't like the (alcoholic) lifestyle. We (treating psychiatrist and patient) thought that alcohol was probably the cause of it (index offence). When I drink, I don't eat properly, I put on weight, and I get sick.
> (Psychiatrist provides advice on diet and exercise.)

Meeting ends and Gregg leaves the room.
Psychiatrist: Seems to be doing extremely well.

This interaction provides several examples of self governance. In particular, 'Gregg' demonstrates that he is able to govern himself responsibly in areas such as employment, finances, and health. He displays insight into his psychiatric condition and the consequences of not attending to the symptoms of his illness. He acknowledges what factors put him at risk of relapse and how to manage these factors. Finally, he displays 'responsibilised resistance' by agreeing that he needs psychiatric care, but requesting a longer period of time between clinical appointments.

Ethical government of the self involves four aspects (Foucault 1985:26-28).[1] The first aspect involves the '*ethical substance*' or the aspect of the self that we seek to act upon (i.e., 'what' we seek to act upon). The ethical substance may be behaviour, desire, intention, feelings, or any other part of the self concerned with moral behaviour. From the above example, the ethical substance that 'Gregg' seeks to act upon is the continuation of improved mental health.

The second aspect of self-formation is the '*mode of subjection*' or how individuals recognize their relation to moral obligations and rules (i.e., 'who' we are when we are governed). The mode of subjection involves the individual's relation to and recognition of rules. In the example above, Gregg acknowledges that his abuse of alcohol leads to poor mental health. By this he recognizes that he is an individual that must attend to both alcohol and mental health issues and that he must practice particular techniques to manage these conditions.

The third aspect is the '*self-forming activity*' or 'ethical work' that one performs on oneself to transform oneself into an ethical subject (i.e., 'how' we govern the ethical substance). Ethical work is the means, or aesthetics, by which we change ourselves in order to become ethical subjects, and may include practicing certain tasks, performing exercises, rituals, and the like. To govern his mental illness and alcohol addiction, Gregg believes that he must take psychiatric medications, abstain from alcohol and attend Alcoholics Anonymous.

The final aspect is a '*telos*' of ethical self-formation (i.e., 'why' we govern or are governed). The telos is the ends or goals sought in ethical self-practice and may include the kind of being to which one aspires, what we hope to become, or the world one hopes to create. In the example provided above, Gregg states that he aspires to be a model patient. Underlying this frivolous statement, intended to be humorous, is the implicit goal of being seen as rational and responsible and thus being eligible for absolute discharge. Towards this end, Gregg provides numerous demonstrations of rationality (e.g., surmising the causes of his mental illness, connecting taking medications with improved mental health, revising legal conditions to facilitate work schedule) and responsibility (e.g., continuing to take medications, attending Alcoholics Anonymous, paying off mortgage, saving for retirement). Through forms of self governance, Gregg demonstrates that he has 'created a self' that could be considered ethical. Indeed, shortly following this Pre-Board conference, the Board of Review granted Gregg an absolute discharge.

Responsibilization

The notion of responsibility is one of the central concerns of forensic psychiatry. Encouraging or requiring patients to 'take responsibility' for one's actions and existence is not unique to contemporary psychiatry. The expectations upon psychiatric patients to take responsibility began with the birth of the asylum where, as Foucault maintains, the chains of restraint were replaced with "the stifling anguish of responsibility" (1965:247). While psychiatric procedures in the early asylums initiated the processes of self-reflection, self-control, and taking responsibility, within the contemporary forensic psychiatric outpatient facility, these processes take on even greater significance.

Individuals found Not Criminally Responsible enter this psychiatric-legal system because they were found to lack responsibility for a criminal act. As a result of this demonstrated lack of responsibility, they are conceptualized as a risk and subsequently in need of professional care and supervision until they can demonstrate an ability to govern themselves with an appropriate degree of responsibility. Nikolas Rose (2000) has described *responsibilization* as the process by which individuals are governed and govern themselves through self-regulation. This process operates through a "plethora of indirect mechanisms that can translate the goals of political, social and economic authorities into the choices and commitments of individuals" (Rose 1996c:58).

There are many opportunities for an individual found NCR to demonstrate responsibility, such as: keeping appointments, demonstrating 'insight', taking prescribed medications, creating and following care plans, and complying with the ubiquitous Board of Review condition of community release – ‘maintaining good mental health’. Many of the practices ~~and~~ procedures of the forensic psychiatric outpatient clinic are designed to provide the opportunity for patients to exhibit responsibility. Likewise, these practices and procedures also allow psychiatric professionals to consider and judge the level of responsibility demonstrated by the patient. In particular, the clinical appointment and the Pre-Board conference provide straightforward opportunities to reveal and assess responsibility.

Two common responsibilization themes appear within the interactions between patients and psychiatric professionals. The first concerns responsibility in relation to mental illness. One of the main objectives of the clinical appointment is to provide the opportunity for psychiatric professionals to determine how responsible patients are in identifying and managing their mental illnesses. The clinical appointment presents the chance for the psychiatric professional to ask questions regarding mental health and the patient to demonstrate responsibility in relation to this matter. For example, the following excerpts illustrate the process of responsibilization with regard to mental illness:

> Psychiatrist: How do you feel about taking meds?
> Bernie: OK. I think of it like diabetes. I have to take it (medications).
>
> -------------
>
> Therapist: What do you need to do to stay out of hospital?
> Marg: Take my meds, stay busy, stay away from religion (patient gets strong religious beliefs). I think I have a good awareness of when I’m getting sick.
> Therapist: What kinds of things can you do to prevent getting very ill?
> Marg: Getting help from the doctor and everyone here; taking (name of medication).
> Therapist: What kinds of things do you do for stress relief?

> Marg: I've no stress right now, but in the past I've exercised, watch TV, movies. I realize I can't get stressed anymore.

As these interactions demonstrate, psychiatric professionals ask questions regarding mental illness which allows patients to demonstrate the ability (or inability, or unwillingness) to take responsibility for identifying symptoms and/or managing mental illnesses. The whole question and response structure is a technique to try to fashion in others a particular self. Individuals found NCR must present consistent demonstrations of responsibility involving mental illness over long periods of time before being considered for absolute discharge.

The second context where responsibility can be demonstrated is related to the legal conditions imposed by the Board of Review. Common conditions include restrictions on travel outside the city, prohibiting contact with certain individuals, maintaining employment, abstaining from alcohol and illegal drugs, and "keeping the peace and good behaviour". Many patient-professional interactions in the forensic psychiatric clinic regarding legal conditions are attempts by psychiatric professionals to determine if the individual found NCR is acting responsibly in relation to the conditions imposed by the Board of Review, as well as an opportunity for patients to demonstrate responsibility; for example:

> Nurse: Anything new?
> Mike: I talked to my mom about (going to her place for) Christmas. I'll have to talk to the Board about it (getting permission to travel out of the city).
> Nurse: You shouldn't have a problem going.
> Mike: I'm not supposed to have contact with my brothers.
> Nurse: Should be OK, unless you screw up.
> Mike: I won't do that.
> ------------
> Bill: Doctor, am I a dangerous person?
> Psychiatrist: We're working hard to make sure you aren't.

Bill: I think I'm responsible enough. Do you honestly think I'm dangerous?
Psychiatrist: I think there is a potential, especially if you got back into drugs.
Bill: I've been on the warrant for 13 years. I stay off alcohol and drugs, come to FACS, stay out of trouble.

Psychiatrist: Did you get a letter from the Board?
Harvey: Yes.
Psychiatrist: What did you think?
Harvey: OK.
Psychiatrist: They are concerned about your drug use.
Harvey: I haven't smoked drugs in a month. And I'm going to NA (Narcotics Anonymous) with a friend.
Psychiatrist: How has it helped you?
Harvey: Learned about drugs, the effects.
Psychiatrist: I'm glad you are honest (about admitting recent marijuana use), but I have to tell you that if you are caught, you will go back to the hospital.
Harvey: But I haven't been caught.
Psychiatrist: But you will be. This is a legal issue. If you are caught smoking, the Board, not me, will send you back to the hospital.

Therapist: What do you think the Board is looking for?
Jean: Hard to say.
Therapist: What are they looking for?
Jean: I've been working four days a week.
Therapist: Good. And we've seen you getting better.

The above examples illustrate attempts to assess and reveal responsibility in relation to conditions imposed by the Board of Review. Complying with conditions demonstrates to the psychiatric professionals and the Board of Review a degree of responsibility that is considered necessary before individuals are granted additional conditions or an absolute discharge. Conversely, resisting or not complying with legal conditions indicates a lack of responsibility which may be considered by psychiatric staff as a risk factor in relapse or re-offence.

Another method of demonstrating and assessing responsibility is through the discussion of what conditions, or changes to conditions, the patient believes would be appropriate or desirable; for example:

> Nurse: When is your board?
> Ann: I think it's coming up within the next four months.
> Nurse: What are you going to ask for?
> Ann: I'm thinking of (asking for) the privilege of living out on my own. But I'm still debating about it. Maybe I'll ask next year to move out on my own. I really like the group home.
> ------------
> Psychiatrist: You are allowed to ask for conditions. What will you ask for?
> Allen: (Shrugs.)
> Psychiatrist: (Lists some possible conditions.)
> Allen: Stay in the community.
> Psychiatrist: What have you done that you could tell the board (to justify staying in the community)?
> Allen: I'm going to school.
> Psychiatrist: What are you doing that will tell the board that you are doing OK?
> Allen: (Shrugs) Nothing.
> Psychiatrist: How about the meds (medications)?
> Allen: I take the meds.

By getting the patient to discuss what they feel are appropriate conditions to request from the Board, the psychiatric professional attempts to gauge the patient's ability or willingness to take responsibility. If the patient plans to ask the Board of Review for something deemed by the psychiatric professional as unrealistic, it demonstrates a lack of responsibility, however, if the patient's requests are seen as reasonable, the individual is considered to be exhibiting responsibility.

In general, demonstrating responsibility in relation to legal conditions is more straightforward than demonstrating responsibility in relation to psychiatric conditions. Compliance with legal conditions is binary – the individual either follows the legal conditions or does not. Compliance indicates responsibility. Insight, appreciation or even detailed understanding of the legal condition does not factor into taking legal responsibility. Responsibility is demonstrated simply through the actions of the individual. Whereas, responsibility in relation to psychiatric conditions is more imprecise and open-ended. Individuals must govern not just their behaviour to be in compliance with psychiatric forms of regulation, but also are expected to demonstrate further responsibility in relation to their mental illness. For example, taking responsibility in relation to mental illness involves not just taking psychiatric medication, but also understanding the nature of the mental disorder, knowing when psychiatric care is necessary, noticing the effects of medications, and reporting these findings to the psychiatric professionals. As discussed in Chapter Five, 'having insight' is an essential component in taking responsibility of a psychiatric condition. Demonstrating responsibility involves a presentation of the self beyond one's overt actions. Individuals who demonstrate the ability to bring together all these actions, thoughts, emotions, and insights in relation to mental illness in a manner consistent with psychiatric expertise are thought to 'be responsible'.

In direct relation to the capacity and demonstration of responsibilization is the conferral of additional freedoms to the individual regulated in this system. These freedoms may include travel outside the city, residing alone rather than in an approved group home, seeking employment, or numerous other freedoms that are generally taken for granted by the general population. Ultimately, individuals found NCR strive for absolute discharge, which could be seen as the triumph of the responsibilised individual. On the other hand, failure to demonstrate responsibility or failures in self management indicate the need for increased surveillance and regulation, including potential readmission to the inpatient facility.

Thus, "taking responsibility" is an ethical endeavour. The process of responsibilization involves practices of the self in which individuals found NCR come to understand and act upon themselves. Of course, this understanding and action on the part of these individuals is regulated within the realm of psychiatric authority and knowledge. Governance operates by inscribing its subjects in particular discourses and "requires them to recognize themselves in the mirrors of truth these hold out" (Pavlich 2000:102). Thus, power is exercised by constituting subjects, and requiring that subjects constitute themselves as particular kinds of selves. Through this twofold process, subjectifying techniques of the self interact with objectifying techniques of governance. The following section explores this interaction in greater detail.

Etho-Politics: The Process of Inculcating Responsibility

Within this psychiatric-legal matrix, psychiatric professionals guide individuals in the arts of self management and work towards empowering the capacities within individuals found NCR for the management of their own lives. Hence, in contemporary psychiatric practice, "the will to cure becomes little more than the inculcation of a particular type of relation to the self" (Rose 1996b:14). In other words, forms of governance seek to act on the ethical practices of subjects. Rose (1999b:477) uses the term 'etho-politics' to describe the attempt to influence conduct of others by acting upon the forces thought to shape their ethical practices. Therefore, through etho-political practices, psychiatric professions attempt to encourage individuals found NCR to constitute a responsible self.

Within the forensic psychiatric outpatient setting, psychiatric professionals guide patients in the art of self management. Rose posits that if madness is the inability to cope with the complexities of life, psychiatry attempts to restore the capacity to cope. Psychiatric professionals "now are required not so much to cure, as to teach the skills of coping, to inculcate the responsibility to cope, to identify failures of coping, to restore to the individual the capacity to cope, and to return the individual to a life with which he or she can cope" (Rose 1996b:12). These tasks are accomplished through interactions between patients and psychiatric professionals. For example, psychiatric professionals will present questions to patients, such as the following:

- How do you know you are getting sick?
- How would I know if you are getting sick?
- Can you tell us what you notice when you are getting sick?
- Do you think you are ill?
- What do you need to do to stay out of hospital?
- What kinds of things can you do to prevent getting very ill?
- What things do you notice when your meds aren't working?

These kinds of questions encourage patients to engage in self reflection, and also involves them in their own psychiatric care. In this fashion, psychiatry is no longer solely responsible for the care and rehabilitation of individuals found criminally insane. Instead, patients must also become responsible for their own care and for the creation of a particular type of self. In other words, the individual found NCR must become prudent in the art of self management (O'Malley 1992). Through etho-political processes, the governance of criminal insanity shifts from a 'social' form of governance (e.g., disciplinary techniques carried out in an inpatient institution), to an 'individualized' form of governance (e.g., patients being encouraged to self govern). With this privatized form of psychiatric governance, the individual must assume prudent and ethical relations with the self and others, while psychiatric professionals work to empower the individual to make rational and responsible choices.

Thus, within the psychiatric outpatient setting, professionals operate from a paradigm that specifies that criminal insanity is not only best governed, but also must be governed, by including the person found NCR in their own management and regulation. This becomes evident through the etho-political strategies put into use by staff, but also by the provisions outlined in Canadian Criminal Code regarding possible dispositions available to those found NCR. As discussed in the previous chapter, the Board of Review can impose virtually any condition on individuals found NCR, *except* psychiatric or any other kind of treatment (*Criminal Code of Canada* s. 672.55). In order for persons found Not Criminally Responsible to receive psychiatric treatment, they must consent to the treatment. Therefore, a person found NCR can choose to receive treatment or not. Likewise, the psychiatric team cannot impose treatment, but [illegible] recommend to the Board of Review that other conditions (e.g., detainment at an inpatient facility, drug testing, daily appointments, etc.) be imposed. These regulations create a situation where an intricate interaction takes place. On one side, psychiatric professionals encourage and entice individuals found NCR to consent to psychiatric treatment. On the other side, patients must make a choice between consenting to treatment which can lead to their being perceived as responsible, insightful, and compliant, or resisting treatment and facing possible indefinite detainment. In essence, it is an agonistic interaction where coercion and regulation hide behind therapeutic practices. So we see, through etho-political techniques, the attempt to manipulate and cultivate pre-existing capacities within subjects occurring simultaneously with the struggle for choice, freedom and autonomy.

The Individual Care Plan (ICP) meeting provides a salient example of the etho-political process. The ICP meeting occurs approximately once a year for most individuals found NCR. The following excerpts taken from an ICP meeting illustrate etho-political processes at work. This particular ICP meeting was thought to be likely the final meeting for this patient, as he was being recommended for an absolute discharge.

The meeting begins with the psychiatric professionals reviewing and discussing the patient's file in his absence. Several broad themes regarding the individual are discussed including psychiatric, medical, criminal, educational, family, and employment histories. Following this discussion, the patient is brought into the conference room. All participants sit on chairs in a semi-circle in front of a white board. The psychiatrist, who generally leads the meeting, stands at the white board.

> Psychiatrist: So what we are going to do today is plan for the future. Get you to think ahead. Where would you like to be in one year from now?
>
> Jeff: I'd like to be out of Dad's house. For now things are good, but in a year, I'd like to move out. In a year, I'd like to make a down payment

> for a house. I tried to get a mortgage earlier this year, but my credit history is shit and they turned me down.
>
> [Psychiatrist is writing Jeff's goals for the upcoming year in a column down the left side of the white board.]
>
> Psychiatrist: Anything else?
>
> Jeff: Another dog.
>
> Psychiatrist: Anything else?
>
> Jeff: A motorcycle.
>
> Psychiatrist: Now, let's ask the team (what goals they would like to see you achieve in the next year). (Name of therapist)?
>
> Therapist 1: How about (become involved in) leisure activities?
>
> Jeff: Sure.
>
> [Psychiatrist writes therapist's goal for Jeff on the board.]
>
> Nurse 1: A girlfriend?
>
> Jeff: (laughs) No, not yet. I just finished a four year relationship.
>
> Nurse 2: Get off the warrant?
>
> Jeff: For sure. Last summer, with the conditions, I couldn't just drop everything and go camping with my friends. I like to be able to do that.
>
> Nurse 3: I'd like to see all of this (list of goals on the board) and continue on medications.
>
> Jeff: For sure, that's a life long thing. Although, I'd like to reduce it.
>
> Psychiatrist: Don't push it (laughs).
>
> Psychiatrist: (My goals for you are that) you continue to do well and still come to see me.
>
> Jeff: Yeah, I'll still come to see you.
>
> Psychiatrist: (Reads the column of goals out loud.)

In the first phase of the meeting, both 'Jeff' and the psychiatric professionals are involved in creating a set of goals for Jeff to achieve in the upcoming year. With this list, Jeff and the psychiatric team establish a set of targets upon which to apply etho-political techniques. After establishing the objectives for the upcoming year, the psychiatrist moves to the centre of the white board and starts a new column.

> Psychiatrist: OK, let's say it's now this time next year and you've achieved all these goals (points to column on left side of board). Looking back over the past year, what was preventing you from getting here?
>
> Jeff: The bank is in the way (of achieving the goals).
>
> [Psychiatrist is writing the obstacles to Jeff's goals for the upcoming year in a column down the middle of the white board.]
>
> Psychiatrist: Why is your credit history so bad?

Jeff: I didn't take care of it.
Psychiatrist: When you were sick?
Jeff: Yeah.
Psychiatrist: What else prevented you from achieving your goals?
Jeff: How far back are we going?
Psychiatrist: Let yourself go.
Jeff: Depression. I didn't care about the future.
Psychologist: You said that you would like to know more about your illness.
[This is added to the list of goals in the left column.]
Jeff: Yeah, (remembering) I'd like to learn more.
Psychologist: What makes you vulnerable?
Jeff: Stress.
Psychologist: What kind of stress?
Jeff: All kinds of stress.
Psychiatrist: Are you stressed right now?
Jeff: No, I'm OK.
Nurse 2: I wonder about motivation? (to achieve these goals).
Jeff: (In the past) I think that was part of the illness. Also taking (illegal) drugs. I was taking drugs because I was sick.
Psychiatrist: I think it's all linked – the illness, the bad credit history, the drugs …
Psychiatrist: (Returns to white board and reads list of obstacles.)

At this point in the meeting, goals for the upcoming year form a column on the left side of the white board and obstacles to those goals form a column in the centre of the board. Again, these columns provide tangible targets for etho-political techniques. Now, the psychiatrist moves to the right side of the board and starts a final column.

Psychiatrist: What do you need to do now (to achieve these goals and overcome these obstacles)?
Jeff: Work, save money, learn more about my illness, don't get in ruts.
[Psychiatrist writes this down on right column of board.]
Psychiatrist: (to each staff member in turn) How can you help Jeff?
Therapist 1: We could talk about credit ratings. I could give some concrete financial advice and support.
Nurse 1: Take your medication.
Jeff: Psssh (meaning 'of course' or 'obviously').
Nurse 2: I hate to push it, but I think you'd do well in group. I think it's a good way to learn about yourself.
Nurse 3: We could answer your questions about meds.

Psychologist: You could ask us about anything.
Psychiatrist: I could continue to provide a relationship with you to provide you with a sounding board.
Jeff: What does that mean?
Psychiatrist: You can come to me at anytime and I'll support you.
Jeff: Sounds good.
Psychiatrist: (reads list of tasks to be completed by Jeff and staff required to achieve goals and avoid obstacles.)
[The meeting ends and Jeff is dismissed from the room. Note: shortly following this meeting, Jeff is granted an absolute discharge.]

At the conclusion of the meeting, the white board contains three columns: goals, obstacles to these goals, and strategies to achieve the goals and avoid the obstacles. All participants in the meeting have contributed to the objective of setting targets, identifying obstacles and devising solutions. This process involves a combination of techniques that Jeff must undertake to govern himself (e.g., take medications, be financially responsible, monitor mental illness), as well as techniques that the psychiatric professionals would undertake to facilitate Jeff's ethical endeavours (e.g., maintain therapeutic relationship, answer questions, provide advice). The contents of the white board are transcribed and become part of the patient's official file.

The ICP meeting represents an etho-political power relation. Psychiatric professionals both encourage and require the individual found NCR to engage in particular forms of self reflection and work towards the creation of a responsible self. Etho-political relations thus represent mutual responsibilities. The psychiatric professional's task is to engage the patient in particular techniques of the self, and the patient's task is to achieve ethical self formation. This relationship is often presented to patients by psychiatric professionals as a cooperative and shared responsibility that each must undertake. For example, psychiatric professionals often use the phrase, "Our job is to ... and your job is to...". In this manner, governing criminal insanity in the forensic psychiatric outpatient clinic becomes privatized and individualized.

Discussion: The New Ethical Territories of Criminal Insanity

Shifting modes of governance within forensic psychiatry highlight new roles for both psychiatric professionals and individuals found Not Criminally Responsible. For psychiatric professionals, the task of regulating criminal insanity in an outpatient setting becomes a matter of encouraging compliance with legal conditions, enticing consent to psychiatric treatment, inculcating responsible thought and actions, and inspiring ethical self formation in the patient. This represents a significantly different set of tasks than is required to regulate psychiatric patients within the inpatient setting. For individuals found Not Criminally Responsible, discharge to the community requires active involvement in their own regulation. These individuals must develop and present skills and abilities that suggest that they are able to govern themselves in a manner that is ethical and responsible. This includes demonstrating insight into their circumstances, the ability to assess and manage situations considered risky, and the capacity to form a self that is seen as responsible. Inability or unwillingness to conduct oneself in an ethical and responsible manner results in re-admission to the inpatient facility and exclusion from society.

These modes of governance are carried out within the interpersonal interactions between psychiatric professionals and individuals found Not Criminally Responsible. Within this strategic relationship, psychiatric professionals coerce, guide, cajole, persuade, compel and force patients to govern themselves in a particular manner. Likewise, individuals found Not Criminally Responsible strive to represent themselves as rational, reasonable, responsible and, ultimately, sane. It is a strategic performance that balances the portrayal of what the psychiatric professionals expect to see and hear with the desire to govern themselves in a particular manner.

From a broader perspective, changing modes of governance of criminal insanity also highlight other important shifts. First, the privatized and individualized nature of regulation in the outpatient setting suggests that the location of reason and rationality shifts from the state, or, more specifically in this case, the discipline of psychiatry, to also include the individual found NCR. The former no longer solely holds a privileged position in relation to reason and rationality, but rather the latter must also claim and demonstrate acuity with these features. Second, aspects such as choice, freedom, autonomy and responsibility become the objectives of regulation. By compelling individuals found NCR to become active in their own governance, these qualities come to be required and necessary, rather than discouraged and marginalized. However, ultimately, the individual is not totally free to create a self that is completely of their own creation. The creation and presentation of self must coincide with the authority of the Board of Review and the discourses of psychiatry.

Chapter Nine – Conclusion

This research thesis commenced from the assumption that the regulation of criminal insanity in a forensic psychiatric outpatient clinic reflects advanced liberal modes of governance. My aim was to offer an empirical mapping of the governmental rationalities and techniques utilized within this setting. It was not to provide ideal typifications or a normative framework upon which to regulate individuals found Not Criminally Responsible.

A case study approach revealed how criminal insanity is regulated through a more complicated mélange of liberal and advanced liberal modes of governance than I originally hypothesised or is theoretically postulated. As summarized below, this hybrid of rationalities and techniques suggests the emergence of new spatial and ethical territories within which criminal insanity is governed. Ultimately, the regulation of criminal insanity, achieved through a complicated interplay of objectifying and subjectifying techniques, struggles to find a balance between the security of society and the freedom of the individual.

Précis of Main Themes

The main themes that emerged in this research project relate to the rationalities and practices of surveillance, risk assessment and management, resistance and ethics. While each theme was discussed separately, in reality, they all intersect and interact, facilitating one another while operating in tandem.

In order to be governed in liberal societies, individuals must be known, and this occurs by making various aspects of the individual visible through assorted techniques of surveillance. For example, in this research setting corporal features of the individual, such as the body, blood and urine, are monitored. In addition, social features, such as relationships, family circumstances, and employment, are scrutinized. Clinical practices carried out within the forensic psychiatric outpatient clinic are structured to allow psychiatric professionals to gather information through direct surveillance as well as providing the opportunity for patients to reveal the findings of self surveillance. Thus, objectifying and subjectifying surveillance practices are often carried out simultaneously.

In contrast to the inpatient setting, opportunities for psychiatric professionals to directly observe patients discharged to the community are infrequent and brief, typically involving only a 20 minute appointment once a week. Consequently, individuals found NCR are enlisted to monitor themselves when not in direct view of professionals. For example, patients must provide reports on medical information, such as when they took medications and any effects of the medication, social situations, and less tangible personal factors such as their thoughts, emotions, feelings, and the like. Individuals who provide self surveillance reports that are consistent with the existing expectations of psychiatric knowledge and expertise are considered to have demonstrated 'insight' – defined as seeing, understanding and articulating one's own internal state.

Discharging patients to the community outpatient setting necessitates a shift from the reliance on disciplinary forms of surveillance to practices that include, and require, the individual to self monitor. These forms of self surveillance are more multifaceted than the 'soul-training' of panoptic surveillance. With self surveillance, individuals must not only act in accordance with the expectations of others, but must also provide 'insight' into their situation and motivations. Thus, self surveillance, and particularly the development of insight, contributes to the active formation of an ethical self.

However, disciplinary forms of surveillance still figure prominently in this setting. Clinical appointments provide the opportunity for officials to examine patients, and if individuals are not able, or unwilling, to practice self surveillance that leads to an ability to demonstrate insight, they will likely come under more intense and direct monitoring by the psychiatric professionals or be re-admitted to the inpatient facility and face more traditional panoptic forms of surveillance.

Surveillance facilitates other forms of regulation, in particular, risk assessment and management. By making qualities of the individual visible, psychiatric professionals are able to assess and manage those features considered to be 'risky'.

Criminal insanity is the personification of uncertainty and ambiguity. A verdict of 'Not Criminally Responsible' is returned when criminal conduct defies our attempts to apply reason and rationality to a person's actions. This inability to impose rationality and order to another's behaviour creates a sense of insecurity. We consider these persons a risk, either to themselves or others, and place them within systems that monitor and regulate their behaviour.

Some of the more common factors that are thought to increase the risk of relapse or re-offence include drug/alcohol consumption, failure to take psychiatric medications, or associating with dubious persons. However, in the forensic psychiatric outpatient setting, a multitude of additional factors are considered in assessing risk. For example, psychiatric, medical, criminal, family and social histories are examined. Corporal features, such as appearance, cleanliness, posture, and body odour are scrutinized, as well as less tangible factors such as demeanour, the ability or willingness to take responsibility for one's actions, and the perceived level of insight the person is thought to demonstrate. In short, there is no single, definite or overriding indicator of risk. Depending on the situation, virtually anything can be considered a risk factor.

As a primary 'site' of risk, individuals found NCR are both objectified and subjectified in relation to risk categories. For example, individuals are constantly being assessed by psychiatric professionals for changes in risk factors. This is accomplished through clinical practices which depend on the knowledge and expertise of psychiatric professionals, as well as actuarial techniques that rely on statistical calculations of data gathered from patients. Contrary to the literature that suggests a straightforward shift from clinical to actuarial risk assessment rationalities, this setting reveals a more complicated picture – one that does not conform to the scenario of one rationality taking precedence over another. Rather, risk assessment forms a complex hybrid of techniques that blends rationalities based on the individual being assessed and/or the personal preferences of the assessor. Most significantly, this research establishes that patients are expected to continuously identify, monitor, discuss and regulate their own risk factors. Consequently, risk rationalities are more than simple techniques for managing passive individuals found NCR. They are strategies explicitly designed to foster particular forms of subjectivity.

Through a combination of passive and active risk assessment strategies, individuals are conceptualised along risk dimensions according to their ability to demonstrate responsible and prudent decisions and behaviours. In particular, individuals are categorized according to three basic risk levels: high, moderate and low. Each of these crude categories is associated with a specific legal designation and a particular psychiatric setting. That is, individuals deemed high risk are held under a full warrant in the inpatient facility; those considered a moderate risk are granted a conditional warrant with discharge to the community; and those thought to be low risk are granted an absolute discharge.

Therefore, conditional discharge to the community represents a liminal stage in the risk management process, one where individuals reside if they are considered not so dangerous as to require constant monitoring, but still unsuitable for absolute discharge. Passage from one designation to the other occurs through an interplay between psychiatric professionals managing institutional and societal risks and the individual demonstrating the ability to identify risks they pose and regulate them responsibly. Ultimately, however, it is impossible to eliminate risk. Instead, there is an imperfect and perpetually incomplete processes of knowing, assessing, managing, steering, regulating and governing risk.

Within the forensic psychiatric outpatient setting, the prevalence of governmental practices, such as surveillance, risk assessment and risk management, suggest that there is a considerable imbalance of power between patients and the legal and psychiatric systems. Although it appears that every aspect of the patient's life is thoroughly regulated by these systems, closer inspection uncovers ample opportunities and instances of resistance. Psychiatric professionals and individuals found Not Criminally Responsible are engaged in strategic and ongoing confrontations where attempts to govern behaviour are often opposed, and where the prospect of such opposition can be prospectively incorporated into the treatment regime.

Here, resistance does not take the form of grand, obvious gestures, such as revolts, strikes, or protests. Rather, it is more subtle, even mundane. Resistance is manifest in everyday practices, such as refusing to answer questions, lying, disagreeing, missing appointments, and the like. These strategies can be divided into two basic categories: tactics of refusal, which involve a direct confrontation between participants; and tactics of avoidance, which seek to evade confrontation. Some common focal points of resistance involve attempts to deny mental disorder, resist psychiatric treatment, and/or avoid surveillance. Resistance strategies are straightforward methods employed by patients in the attempt to improve their circumstances and control aspects of their lives and identity.

Such everyday forms of resistance are germane to the broader study of social relations as it underscores that not all resistance is or needs to be organized, collective or entail grand gestures. In fact, since much of contemporary governance is localized, fragmented, and individualized, the sheer frequency and ubiquity of subtle, everyday forms of resistance are extremely salient and deserve greater analytical attention.

Attempts to govern behaviour and the corresponding resistance efforts illustrate the complexity of power relations which are always comprised of reciprocal interactions whose outcome is never predetermined or certain, but rather in a constant state of confrontation and emergence. This complicated interaction is clearly highlighted in the notion of 'responsibilised resistance', which refers to how individuals found NCR are expected to strike a mix of subtle non-compliance and prudent behaviour. What officials seek is for patients to demonstrate a delicate balance between too much and too little resistance. It is resistance with a demonstration of responsibility. Such displays of resistance expose power relations while they underscore the capacity, creativity and humanity of individuals found NCR.

As implied by notions such as insight, self-regulation and responsibilised resistance, a significant empirical finding of this research is that part of what is occurring in this setting is the ethical formation of the self. Governance of criminal insanity in a community forensic psychiatric setting not only advocates, but requires, self governance. This form of regulation operates by encouraging and nurturing certain capacities. For example, patients must be accountable for their behaviour, capable of prudent action and choice, and shape their lives and identity according to the moral code of individual responsibility and community obligation. Within this setting, psychiatry is not solely responsible for the regulation of the criminally insane. Instead, individuals must become responsible for their own care, management of illness, rehabilitation, regulation of risk, surveillance, and so on.

To meet such expectations, the criminally insane must undergo a dramatic metamorphosis. At the time of a “Not Criminally Responsible” verdict, the image that the general population and the psychiatric-legal system has of criminal insanity is that of an irrational, unpredictable, ambiguous, and utterly dangerous individual. However, by the time the person is discharged to the community, and especially before they are granted absolute discharge, psychiatric professionals and the Board of Review must believe that the patient is capable of taking responsibility, acting reasonably, and exercising free will and personal choice. Throughout their tenure as NCR, the individual must therefore demonstrate one of the most dramatic ethical transformations imaginable. The following table schematically highlights some elements of this change.

Table 3. Ethical Transformations of the Criminally Insane

Unpredictable	→	Knowable
Ambiguous	→	Apparent
Uncertain	→	Sure
Dangerous	→	Safe
Irrational	→	Sensible
Ungovernable	→	Dependable
Irresponsible	→	Prudent
Insane	→	Sane

In very few other social settings does success require such a comprehensive transformation. Of course, these changes are never fully consolidated. Individuals must convince the psychiatric professionals and the members of the Board of Review that they have made sufficient progress in this endeavour. Change occurs (sometimes very) slowly over a long period of time and is demonstrated in a multitude of forms, from risk scores to informal interactions. Psychiatric professionals encourage, entice and inculcate a process of individual ethical formation while simultaneously monitoring this process. For the patient, successful transformation entails an ongoing, consistent presentation of self that corresponds with the legal-psychiatric notion of an ethical self. Those who can transform their identity in the expected direction are promised the prospect of an absolute discharge; those who cannot, remain in the liminal state of the outpatient clinic or are returned to the inpatient setting. In essence, absolute discharge is the reward for individuals who can form and present a self that is seen by psychiatric professionals and the Board of Review as responsible, rational, reasonable and sane.

Put succinctly then, governing criminal insanity relies on surveillance. Surveillance facilitates other forms of regulation such as risk assessment and management. The active participation of the subject is required in such regulation, but also provides opportunities for resistance. It is in practices of surveillance, risk, and resistance where subjects form and present particular formations of self.

In the forensic psychiatric outpatient clinic, this intricate process is accomplished through interpersonal interactions between patients and psychiatric professionals. Analysis of these power relations provides us with both a detailed understanding of how micro-political objectives are strategically achieved, as well as a reflection of macro-political rationalities of governance.

The Shifting Rationalities and Practices Governing Criminal Insanity

A central objective of this research project was to compare the regulation of criminal insanity against developments in contemporary forms of governance. An obvious starting point for such an analysis, and one that informed my initial assumptions, is that the forensic psychiatric outpatient setting exemplifies a shift from liberal to advanced liberal modes of governance. Further reflection suggests that while there is some validity to this premise, what is occurring here is a more complicated transformation than is often theoretically postulated.

One approach in exploring the relation between the governance of criminal insanity and contemporary social developments is to consider how subjects are conceptualized in relation to forms of regulation. For example, in the 19th century, criminal insanity was understood as the failure of the rational, reasonable subject. The acts committed by the insane did not fit into predictable, logical categories. As a result, these individuals were incarcerated which effectively removed them, and the danger they presented, from society. Throughout the 20th century the discipline of psychiatry dominated the identification and management of criminal insanity. Through this form of knowledge and expertise, insanity was constituted as an abnormality. These individuals were considered incapable of functioning in 'normal' society and were institutionalized in psychiatric facilities. Here, the objective was to rehabilitate the 'deviant' subject with the (seldom achieved) goal of incorporating them back into society.

In contemporary times, criminal insanity is understood as entailing both irrational and abnormal behaviour. Individuals found NCR are institutionalized, which effectively neutralizes the danger they are seen to present, and they face the disciplinary tactics of psychiatrists. However, unlike previous responses to criminal insanity, contemporary legal codes provide the meaningful possibility of community discharge and absolute release. Therefore, nearly all individuals found NCR, after spending some time in an inpatient facility, will be discharged to a forensic psychiatric outpatient clinic and most will eventually be granted an absolute discharge. When released to the community, these individuals face diverse and fragmented forms of regulation, including the expectation that they govern themselves.

However, these changes are not as straightforward as presented. Rather than viewing the regulation of criminal insanity as having shifted from liberal to advanced liberal modes of governance, it would be more accurate to speak of an amalgam or hybrid of governmental rationalities and techniques. Within the contemporary regulation of criminal insanity, disciplinary forms of regulation persist and are reconfigured to accommodate governance in a community setting. For example, panoptic surveillance exists in combination with reliance on patient insight; and clinical risk assessment is utilised in association with actuarial risk assessment. The result is not a smooth transition, but a messy, lurching and fragmented fusion of rationalities and techniques. This messiness mimics the confusion in the concept of criminal insanity itself, which entails an amalgamation of the determinist discourses of psychiatry and the volitional discourses of law.

In reference to the "shifting terrain" of contemporary forms of governance, Pavlich (2001) proposes the term "co-social" to refer to the emergence of nascent governmental mechanisms that evolve alongside the long-established social forms of governance. "These governmentalities are not predicated *on*, or *after*, social governance, but emerge somewhat parasitically *with* social calculations of rule" (Pavlich 2001:4, emphasis in original). Thus, social governmentalities are not precursors or antecedents of emerging governmentalities, but rather each informs and interacts with the other.

In short, governing criminal insanity in the community does not characterise a definite shift from erstwhile modes of governance, but rather represents a constant process of revising a perpetually unfinished product (Hunt and Wickham 1994; Miller and Rose 1990; O'Malley 2001).

Conclusion: The New Spatial and Ethical Territories of Criminal Insanity

Despite the discontinuous, unstable and perpetually shifting nature of contemporary modes of governance, several new and significant features concerning the regulation of criminal insanity merit a final note of discussion. First, and most obvious, is the increased importance of the forensic psychiatric outpatient setting. Progressively, it draws upon the language of 'community' rather than of 'society' to describe the regulation of criminal insanity. Here, focus shifts from the single, interlocking network of social problematisations, institutions and practices, to the diverse, fragmented and individualised labyrinth of the community.

The 'community' has emerged as a dominant discourse across many different realms, notably in the areas of criminal justice and health care. Within these domains, the management of individuals 'in the community' is often considered a positive, progressive and modernizing phenomenon. However, close inspection of community-based care and corrections exposes many areas of concern (see Cohen 1985). Foremost, community settings necessitate numerous and novel forms of coercion, many of which are not obvious at first examination.

Community-based care and control is clearly evident in the contemporary governance of criminal insanity. Practically from the moment that the 'Not Criminally Responsible' verdict is rendered, the goal of the psychiatric system is to manage these individuals in the 'community' outpatient clinic. Within this setting, novel forms and targets of regulation are established. For example, a much wider variety of corporal and social features of the individual come under scrutiny. Concomitant with this increase in surveillance, is the proliferation of factors that come to be considered 'risky'. Put simply, the more things that are seen, the more that becomes conceptualised as possibly risky and in need of management. This increase in the methods and targets of regulation also presents more and different opportunities for resistance than would be possible in the inpatient setting. Thus, resistance to power strategies is not only a method to oppose forms of rule, but also a means to attempt to conduct one's life in a certain manner and create an identity of one's choosing.

The other significant feature of the new rationalities and techniques of regulating criminal insanity is the increased reliance on self governance. Individuals found NCR who are discharged to the community are expected to regulate themselves. They must monitor their own thoughts and behaviours and report the findings to the psychiatric professionals. They must also be able to identify and manage any risks they are thought to pose. In short, they must become responsible for themselves. Those who can govern themselves in a manner that is thought to be rational, reasonable and responsible are granted additional liberties, including absolute discharge.

These contemporary developments denote new roles for both psychiatric professionals and individuals found Not Criminally Responsible. The conventional tasks of psychiatry (euphemistically, activities such as treating, curing and rehabilitating) are supplemented by more ordinary and indirect activities. Psychiatric professionals employed in the outpatient clinic must engage in mundane efforts to convince patients to monitor and regulate themselves, persuade them to take responsibility for their actions, evaluate if they are successful in these endeavours and involve community partners in all of these tasks. On the other side of the coin, individuals must become more actively involved in their own care and management than when they were inpatients. They must monitor, regulate, and take responsibility for themselves. More fundamentally, they must create and present an ethical self through practices of self-formation that straddle the expectations of the legal and psychiatric systems and personal desires. This is the essential pursuit of individuals found Not Criminally Responsible.

To conclude, I would like to return to the metaphor of a balance mentioned at the beginning of Chapter One. Within the forensic psychiatric outpatient clinic a metaphorical balance is struck between providing security to the community through the regulation of a potentially dangerous person, and the individual's struggle for personal rights, independence and freedom. As the preceding chapters have outlined, the two sides are weighed by many factors that determine in which direction the balance tips in specific cases. Security of the community is emphasized when the individual is thought to present an imminent threat; whereas freedom is bestowed when the individual demonstrates that he or she is able to take responsibility for managing those threats to security. Mirrored in this balance is the fundamental tension between power relations that objectify the individual versus power relations that subjectify.

The image that predominates is freedom *versus* security. Either the community can be safe or the individual can be free. However, Bauman (2001) reminds us that the exchange between freedom and security is not a choice between good and evil. Each provides potential benefits and drawbacks. For example, the advantage of security is the safety it offers, but taken to the extreme securitization efforts result in totalitarian relations. Likewise, in exchange for the greater freedom of community discharge, individuals found NCR must endure invasive forms of regulation that seek to govern all aspects of their existence. On both ends of the balance, therefore, gains are countered with loses (Bauman 2001:42).

The community discharge process implies a notion of progress. The care and management of the criminally insane in a community setting is thought to be less onerous on the freedom of the individual, that is, more progressive, liberating and humanizing. The opposing perception of community discharge is that these individuals pose a threat to the community which requires rigorous monitoring and regulation. Thus, individuals found Not Criminally Responsible who are discharged to the community exist in a liminal position between security and freedom. Here, autonomy, capacity and responsibility become essential, qualities to be encouraged and emphasised rather than marginalized. However, these persons also face pervasive technologies and practices of regulation – tactics in which they themselves must participate. They enjoy the freedom of living in the community away from the constant gaze of psychiatric professionals, yet their lives continue to be, in effect, entirely governed by the psychiatric and legal systems. They exist in a space liberated from the physical restrictions of the inpatient unit, but are now confined through ubiquitous forms of self governance.

Therefore, the community is not simply a location or a group of people but rather a form of regulation. This turn to community-as-regulation must be viewed in light of the forms of power it entails. Its defining characteristic is the reliance on self governance. This type of regulation can be described as 'soft power'. It requires the active involvement and contribution of the subject. It is built-in to everyday tasks and responsibilities, and therefore becomes pervasive, permanent and almost invisible. On the whole, these contemporary governmental rationalities and practices, occurring in the name of a more free and humane care in the community, are, arguably, more assiduous than forms of regulation experienced by the criminally insane in other settings or other eras.

Indeed, gains mixed with losses.

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Endnotes

Chapter One - Introduction

[1] Throughout this dissertation, I use the terms "not guilty for reasons of insanity", "criminally insane" and "Not Criminally Responsible" synonymously. In Canada, since the passage of Bill C-30 in 1992, the correct term is "Not Criminally Responsible on Account of Mental Disorder".

[2] For discussions on government and governmental rationalities and technologies see Foucault 1991; Gordon 1991; Miller and Rose 1990; Rose and Miller 1992.

Chapter Two – Historical and Legal Framework

[1] Translated from Latin, *actus reus* means 'guilty act' and *mens rea* means 'guilty mind'.

[2] Before 1892, Canada was ruled under English common law.

[3] Ontario published a manual outlining the role and duties of the Board and guidelines for patients, lawyers, patient advocates and psychiatric consultants (Haines 1984), however these procedures were not uniformly followed by the other provinces (Glancy and Bradford 1999:302).

[4] Owen Swain attacked his wife and two infant children in bizarre manner, believing that they were possessed by devils and that he was exorcising them. His victims suffered only superficial physical injuries. At the trial, Swain's wife testified that he appeared to be fighting with the air and talking about spirits.

[5] Caution needs to be exercised when interpreting these statistics. This calculation was determined by using the Stellar (2003) report which lists the total number of new NCR verdicts in the 2000 *calendar* year, and the Thomas (2002) report which lists the total number of criminal code cases for the 2000/01 *fiscal* year. In addition, the Thomas report does not include statistics from all provinces and territories. Thus, the rate of NCR verdicts as a percentage of total criminal code cases was calculated using only those provinces/territories that reported both the number of NCR verdicts and the number of total criminal code cases.

[6] Bill C-30 did not significantly change the mental disorder *defence* itself. Both the current and previous mental disorder defences are based on the *M'Naghten* Rules. The main differences, as discussed in the body of this section, are changes in terminology (e.g., 'criminally insane' becomes 'Not Criminally Responsible' and 'natural imbecility or disease of the mind' becomes 'mental disorder') and changes to the disposition of those found Not Criminally Responsible (s. 672.54).

[7] The most common conditions are to report regularly to a forensic psychiatric outpatient clinic, to abstain from alcohol and illicit drugs, and to "maintain good mental health".

Chapter Three – Theoretical Framework

[1] Goffman (1961:xiii) defines 'total institutions' as "a place of residence and work where a large number of like-situated individuals, cut off from the wider society for an appreciable period of time, together lead an enclosed, formally administered round of life.

[2] For a detailed discussion of 'the welfare state' see Jacques Donzelot's (1991) essay, 'The Mobilization of Society', in *The Foucault Effect*.

[3] 'The social' refers to the interlocking network of problematisations (e.g., social problems, social issues), institutions and practices (e.g., hospitals, social work, social insurance), laws and legal jurisdictions (e.g., family court, juvenile court), a variety of experts and authorities (e.g., social workers, teachers, police officers) and 'responsibilized' individuals (e.g., patients, pupils, juvenile delinquents) (Dean 1999:53). This network represents the space of liberal government.

[4] Gordon (1991:21) defines 'irreducible' as meaning personal sentiment which cannot, in the end, be explained from any other, more fundamental causal principle; and 'non-transferable' as meaning no external agency can supplant or constrain the individual determination of preferences.

Endnotes - continued

Chapter Four – Methodological Framework

[1] On rare occasion, the Board of Review permits an individual found NCR to attend a psychiatric clinic in another city in Alberta.

[2] Throughout the data collection period, the number of individuals found NCR discharged to the community would fluctuate slightly, as individuals would be discharged from or admitted back to the inpatient facility, or granted absolute discharge.

[3] Throughout this document, I use the generic term 'psychiatric professional' to refer to individuals from any of the disciplines that practice in the clinic.

Chapter Five – Surveillance

[1] The Diagnostic and Statistical Manual (published by the American Psychiatric Association) is a widely used manual that lists different categories of mental disorders and the criterion for diagnosing them.

Chapter Six – Risk

[1] See Ericson (2007) and O'Malley (2004) for detailed analyses of the intricacies of risk and uncertainty within liberal governmentalities.

[2] For detailed discussions of the concept of danger, see Castel (1991) and Pratt (1997;1999).

[3] For detailed discussions of actuarial and clinical risk assessments see Ægisdóttir et al 2006 and Hilton et al 2006.

[4] In a common scenario, individuals are allowed to leave the inpatient facility during the day to attend school or employment, but must return to the unit in the evening.

Chapter Seven – Resistance

[1] Throughout this chapter, *strategies* refer to the more general ways of thinking about governance, while *tactics* refer to the more specific actions or techniques of governance.

[2] See Marx (2003) for a list and a discussion of the various tactics used to subvert the collection of personal information and disrupt surveillance.

[3] Individuals found Not Criminally Responsible cannot resist directly the administration of actuarial risk assessment tools that are used in this setting because these instruments are completed by psychiatric professionals without the knowledge or input of the patient. Few, if any, individuals found NCR would even be aware that such instruments are utilised in this setting. The only opportunity to resist this form of risk assessment would be to fabricate answers on the "Summary of Client Views" questionnaire (e.g., "Do you see yourself as having any mental health problem?"; "Are you happy with your friends/social life?") which is used by the therapist to aid in completing risk assessment tools.

[4] A regional alcohol and drug rehabilitation program.

[5] The high incidence of failure of resistance tactics is partly due to the nature of the data collection. Instances of resistance only become known when they are exposed. Within this research, acts of resistance are made visible when they are discovered or challenged by psychiatric professionals. Due to the nature of the enterprise, successful acts of resistance are not always visible or detected, nor do individuals readily draw attention to their acts of resistance.

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[1] See also Davidson 1994:118; Dean 1999:17; Foucault 1997c:263-265; Simons 1995:34-36.